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ABSTRACT

An study explored the extent to which integration of a philosophy of health in the educational curricula of nurses, midwives, and health visitors in Britain had been achieved. Four case studies and consultancy were undertaken, and both pre- and postregistration curricula were examined. Semistructured interviews, discussions, classroom observations, and questionnaires were used with college staff, students, and hospital and community practitioners. Findings indicated that a philosophy of health had not been successfully integrated into pre- and postregistration courses for nurses and midwives. Community nursing courses appeared to have achieved more success. Aspects of a philosophy of health and health promotion were well represented within the curricula but in a fragmented and disjointed way. The predominant philosophy of health espoused in most curricula tended toward traditional approaches that emphasized physical health focused on individual lifestyles rather than advocacy, empowerment, community participation, and development. Three principal recommendations were as follows: nurses, midwives, and health visitors should develop their own conceptualization of health promotion; all educational programs should include regular consolidating sessions on health promotion; and nursing facilitators should help and direct students and practitioners to apply health promotion theory to practice. (Appendixes contain instruments and 94 references.) (Author/YLB)

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A CURRICULAR REVIEW OF THE PRE- AND POST-REGISTRATION EDUCATION PROGRAMMES FOR NURSES, MIDWIVES AND HEALTH VISITORS IN RELATION TO THE INTEGRATION OF A PHILOSOPHY OF HEALTH : DEVELOPING A MODEL FOR EVALUATION

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U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
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PREFACE

A CURRICULAR REVIEW OF THE PRE- AND POST-REGISTRATION EDUCATION PROGRAMMES FOR NURSES, MIDWIVES AND HEALTH VISITORS IN RELATION TO THE INTEGRATION OF A PHILOSOPHY OF HEALTH: DEVELOPING A MODEL FOR EVALUATION

The Board is pleased to publish the report which provides valuable information in the areas of curriculum development in pre- and post-registration education programmes.

Through a variety of means including validation, monitoring and evaluation, the Board ensures that education for practice continues to be relevant both professionally and academically. Research based evidence provides a further important dimension for the development of policy. The findings and recommendations from all the research commissioned by the Board will be considered with a view to confirming or developing the Board's educational policies.

The findings and recommendations in this Final Report will be of particular interest to teachers, practitioners and managers and all those directly and indirectly involved in health promotion and health education.

A Curricular Review of the Pre- and Post-Registration Education Programmes for Nurses, Midwives and Health Visitors in Relation to the Integration of a Philosophy of Health : Developing a Model for Evaluation

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ABSTRACT

A shift towards a philosophy of health has been one of many changes with which the caring professions have recently been involved. This project was a short exploratory study commissioned by the English National Board of Nursing, Midwifery and Health Visiting, which used illuminative evaluation to determine the extent to which integration of a philosophy of health in the educational curricula of nurses, midwives and health visitors had been achieved. Four case studies and a consultancy were undertaken in centres representing a geographical distribution within England. Both pre- and post-registration curricula were examined. Semi-structured interviews, discussions, classroom observations and questionnaires were used with college staff, students and hospital and community practitioners.

It was found that on balance a philosophy of health had not been successfully integrated into pre- and post-registration courses for nurses and midwives. Community nursing courses appeared to have achieved more success in this respect. Aspects of a philosophy of health and health promotion were well represented within the curricula, but in a fragmented and disjointed way. The predominant philosophy of health espoused in most curricula tended towards traditional approaches which emphasised physical health focused on individual lifestyles rather than advocacy, empowerment, community participation and development.

A variety of recommendations were made. Three principal proposals are that firstly nurses, midwives and health visitors need to develop their own conceptualisation of health promotion as distinct from a generic philosophy of health. Secondly, all educational programmes should include regular consolidating sessions on health promotion throughout the duration of all courses. The third proposal is to introduce nursing facilitators to help and direct students and practitioners to apply health promotion theory to practice.

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Dr Rosemary Pope, Research Department, Health Education Authority
Mr John Wells, Principal of the Royal College of Nursing's Institute of Advanced Nursing Education, London.

Special mention is given to Mrs Sonia Crow for her help and advice and to Mr John Wells who in his role as Principal of the Institute, gave us structural support to complete the project in addition to our teaching responsibilities.

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To all our thanks.

CHAPTER 1

INTRODUCTION

Over the last decade, the nursing, midwifery and health visiting professions have been undergoing a period of constant and relentless change. The Project 2000 report - 'Project 2000 - A New Preparation for Practice', published in May 1986 by the United Kingdom Central Council (UKCC) heralded a number of proposals for changing the educational structure and knowledge base of the professions. One of the most dramatic was the proposed shift to a philosophy of health as a basis for education and practice rather than the traditional disease orientated approach. This major paradigm shift was just one of a number of educational, political and ideological changes faced by educators, students and practitioners.

Other changes Included a major restructuring of education programmes and the move towards merging nursing schools to form larger teaching units and integrating them with colleges of further and higher education. The hospital based training to prepare general and specialist state registered or enrolled nurses was slowly replaced by the Diploma in Higher Education (DipHE), offering an eighteen month common Foundation Programme and a choice of Branch studies in adult, child, mental health or mental handicap nursing. Some institutions also offered direct entry midwifery courses as part of the Project 2000 pre-registration options.

The new pre-registration programmes removed student nurses from their traditional role as principal care givers, releasing them for theoretical studies and giving them supernumerary status during clinical placements. A new type of support worker was introduced to supplement the workforce and training schemes for the National Vocational Qualification (NVQ) set up.

A system was also introduced to integrate, unify and simplify course admission called Accredited Prior Experiential Learning (APEL) and the Credit Accumulation and Transfer System (CATS) enabling a modular system of higher education to flourish. The English National Board (ENB) Higher Award (1991) offers a complementary path for nurses, midwives and health visitors to consolidate and validate their education and experience.

Other initiatives associated with Project 2000 have occurred in post-registration and continuing education with the introduction of the Post-Registration Education and Practice Project (PREPP) and the Community Education and

Practice (CEP) reports (UKCC 1990,1991). Both initiatives address the ongoing educational needs of practitioners.

National educational reforms both impinge and reflect those taking place within nursing, midwifery and health visiting. The Further and Higher Education Act (Great Britain. Parliament 1992) and the entry of the polytechnics into the university system removed the binary divide between institutions of higher learning to create a unified funding system. The government announced that its target of one in three young people entering Higher Education had been reached six years earlier than planned, despite only a 7.3% increase in budget. The lion's share of the increased work load had been achieved by Higher Education Colleges with a 27% increase. The 'old' universities saw a 7% rise in entrants in 1993 and the 'new' universities a 1% reduction in applications (Guardian 27 November 1993).

Major political and ideological changes have also resulted in the National Health Service (NHS) reforms (DH 1990). The origins of the reforms can be traced to the implementation of the Griffiths Report (1983) and the introduction of executive general managers to head up the service. The Korner recommendations (NHS/DHSS 1982-1984) saw the development of computerised information systems for monitoring hospital and community services, personnel, finance, workload and patient/client throughput.

More recently, the NHS and Community Care Act (Great Britain.Parliament 1990), derived from the two working papers, Working for Patients (1989) and Caring for People (1989) detailed changes in funding for both service and education (Working Paper 10, 1989). They also re-emphasise the importance of primary health care and encourage the shift away from hospitals in health service provision.

The government's message conveyed in these documents, clearly supports the emergence of the internal market, hospital and community trusts and the purchaser/provider split, creating a new language and ideology committed to cost efficiency. As part of this commitment there have been a number of reports on skill mix, some of which propose reductions in the ratios of qualified nursing staff (NHSME 1992). Others suggest the importance of qualified nursing staff to quality patient care (Higgins and Dixon 1992).

Another important policy influence regarding health promotion has been the 1992 Health of the Nation White Paper (DH 1992). For the first time, targets to reduce disease (strokes, heart disease, mental illness, cancers, Human Immune

Deficiency Virus/Acquired Immune Deficiency Syndrome [HIV/AIDS], accidents) were identified in quantifiable terms. But for some commentators, the document offered a constricted view of disease prevention based on behavioural and lifestyle factors rather than health promotion through personal empowerment, environmental and economic measures (Public Health Alliance 1992).

Changing and expanding values within nursing, midwifery and health visiting in response to client and patient needs go beyond the Health of the Nation proposals. For example, holistic care and the increasing importance of health promotion and education plus the use of nursing models to guide practice, have been prominent features of recent nursing philosophy.

It was within this context of change that this research project was commissioned by the ENB. It sought to unravel the impact of a shift in philosophy from one which took disease and its nursing care as its starting point to one which integrated a philosophy of health in order to develop the nurse, midwife or health visitor as a health promoter and educator.

Following the ENB specification the project aimed to develop an approach to evaluating the integration of a philosophy of health within educational curricula. The ENB recognised the influence of the World Health Organisation (WHO) declaration at Alma Ata (WHO 1978) in emphasising health and prioritising primary care in response to changing disease patterns and population needs. The Board therefore wished to assess the extent to which a range of educational curricula had successfully incorporated the shift in emphasis.

Included in our curricular review were pre-registration DipHE courses, health visitor courses, direct entry midwifery courses and post registration nursing courses in research, the care of people with HIV/AIDS, Critical Care and second to first level nurse programmes.

The Board also wished to gain a perspective on the geographical distribution of the programmes. We selected courses in England representing a wide geographical spread.

As colleges prepare to resubmit curricula for approval and license to function, evaluation is vital for a number of points:

* to monitor progress and to feedback to course providers so that

improvements can be made;

* to inform future educational policy;

* to promote high quality educational programmes;

* to ensure that value for money occurs.

The move towards a philosophy of health and the increasing importance of health promotion in nurses', midwives' and health visitors' role has many advantages for the professions and for the community generally. A major feature of health education and health promotion is self-awareness, that is, awareness of one's own health beliefs and coping strategies and awareness of the difficulties and constraints inherent in one's own behaviour modification, attitude change, or emotional development. Enhancement of these attributes within the professions, can only be of benefit to the individuals themselves, their families, colleagues and ultimately their patients and clients.

Mediation, negotiation, equality, advocacy, autonomy, enablement are some of the many concepts which underpin a philosophy of health and health promotion and the principles upon which these concepts are built are common to all branches and divisions of nursing, midwifery and health visiting. An educational philosophy of health which permeates all courses potentially provides a unifying force in the separate branches and divisions, permitting nurses, midwives and health visitors to identify with each other to emerge as a stronger, healthier and unified profession.

The teaching methods consonant with a philosophy of health also provides a unifying force by providing opportunities for shared learning, rewarding team work and collaborative working relationships with each other, medical colleagues and patients. These empowering methods central to teaching about health promotion can only increase nurses', midwives' and health visitors' confidence and assertiveness, so enabling them to work more equally with medical colleagues and consequently to work less defensively with patients. Ultimately patients and clients will benefit from professionals confident enough to communicate feelings and to work in ways which facilitate and enable their patients' and clients' health potential to flourish.

Finally the assumption is that an increase in the health education and health promotion skills of nurses, midwives and health visitors will lead to decreases in disease, illness and disability, demonstrated in fewer hospital readmissions,

GP visits and reduced medication costs. Although harder to quantify, it is also likely there will be psychological benefits from a reduction in preventable disease and an increase in coping strategies for patients suffering chronic ill health.

Evaluation model

The need to evaluate curricula has been recognised by educators and policy makers over the years. There are various research issues however, which the present project needs to consider beyond classroom based education.

For a topic such as 'health' which has both theoretical and practical components, evaluators need to look at students' knowledge, skills and attitudes and how they apply them in the clinical setting.

Focused discussion groups and open ended questionnaires for students and practitioners enable us to answer these questions.

Both long and short term consequences of a curriculum immersed in a philosophy of health are important. It is mainly the short-term component which is explored in this research. Long term assessment of health promotion skills might be seen in future research where skills of diplomates, along with their preferred models of health promotion and their abilities to enhance their own health might be assessed.

The interpretation of the philosophy of health by the educational institutions may vary considerably and the various interpretations of the curriculum planners and those called upon to teach the curriculum need to be addressed. Each student and practitioner can only adopt a particular stance in relation to a philosophy of health which ultimately fits in with her/his own moral or cultural view of nursing, midwifery or health visiting.

The most appropriate conceptual model which addresses all these pertinent evaluative issues was considered to be that of illuminative evaluation (Parlett & Hamilton 1977). This approach provided the framework from which to design a model of evaluation to determine the extent and effectiveness of a move towards a philosophy of health in nursing, midwifery and health visiting curricula.

CHAPTER 2

LITERATURE REVIEW

The literature identified as relevant to this project falls into the following categories. Literature relevant to the WHO perspectives on a philosophy of health; the educational and policy statements issued by the United Kingdom Central Council of Nursing, Midwifery and Health Visiting, (briefly touched upon in our introduction); supporting literature issued by the Department of Health; a literature survey on the evaluation of the implementation of a philosophy of health into educational curricula of nurses and midwives; and recent research on the role of health promotion in the nurse's role.

Over the latter part of the twentieth century, global health needs have changed dramatically. In response to this situation, the World Health Organisation (WHO) held a conference in 1978 (WHO 1978). In the Alma-Ata Declaration, the delegates called for urgent action by governments, health and development workers to protect people and promote their health all over the world. Recommendations were also made to emphasise primary health care and health planning based on individual and collective needs. Nurses, midwives and community nurses were identified as holding key roles in responding to the expressed health needs of the community.

This philosophy was developed further in the 1984 WHO discussion document. The concepts and principles of health promotion were spelled out (see appendix i) including the importance of educating and re-educating health professionals to take on nurturing and enabling roles to facilitate its implementation. This document was designed to inform discussion on health promotion which is states, 'represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future... Health promotion is also seen as a process of enabling people to increase control over and to improve their health'(WHO 1984).

In a statement for the International Council of Nurses, Baumgart believes that nursing's accomplishments 'should serve as a springboard for constructing an agenda aimed at making nursing a dynamic force in bringing health care to all by the 21st century'. Baumgart also sees nursing 'in the forefront of the process of putting "health" into health care' (Baumgart 1983, p.13)

Nurses in the United Kingdom have taken up these challenges as reflected in such initiatives as Project 2000 (UKCC 1986), the Post-registration Education and Practice Project (PREPP) (UKCC 1990), Proposals for Community

Education and Practice (CEP) (UKCC 1991). The Department of Health's nursing strategy (DH 1989) currently under review and the government White Paper, Health of the Nation (DH 1992) further subscribe to these challenges.

The strategy proposed in the latter, for improving the Nation's health focuses on five key areas: coronary heart disease and stroke; cancers; mental illness; HIV/AIDS; and accidents. The White Paper identifies the need 'to establish a direct link between what it does and the results in terms of the amount of health gained by individuals and the population as a whole'. This present study fits in well with this challenge by proposing to evaluate the extent and effectiveness of integrating a philosophy of health into the educational curricula of nurses, midwives and health visitors.

In particular, the educational initiatives associated with Project 2000 aim to prepare nurses for the 21st century by providing:

* a system of education geared to meeting future health needs;

* a group of professionals able and willing to adapt rapidly to change;

* a better relationship between education and service;

* a simpler overall pattern of preparation, whilst maintaining and improving standards;

* a greater degree of professional unity and constructive participation in health policy.

(UKCC 1986)

Over the last decade, health policy in Britain has moved towards community care, whilst maintaining hospitals and developing high technology services to meet the needs of the acutely ill. If the nursing profession is to respond to these changes then the initial preparation of nurses must become much less hospital based. New thinking has to be developed around concepts of health and practical experiences in a whole range of care settings. Thus, 'educational institutions of the future will need to relate to a whole geographical "community" and to all the health problems and all the health care facilities in that catchment area' (UKCC 1986). We return to the UKCC (1986) document in Chapter 4 and a discussion of how we used it to aid our data analysis.

The PREPP (1990) and the CEP (1991) reports built on the Project 2000 initiatives, by addressing the educational needs of practitioners.

Proposals were made for developing professional knowledge and practice based on the WHO recommendations. In order to inform these developments, a review of health needs was undertaken by the Project 2000 and PREPP projects. Three key findings emerged:

* the nature of health needs are changing rapidly and are closely related to social needs, age and circumstances of the patient or client;

* there are a number of health problems that could be prevented through primary, secondary or tertiary intervention at individual, family and community level;

* there is an increasing number of patients being cared for within the community, including patients discharged early from hospital; the frail elderly and those with mental health problems and chronic disabling conditions (UKCC 1991).

We also undertook a literature survey to ascertain the current situation in relation to the integration of a philosophy of health into current nursing education curricula. There appeared to be a paucity of research-based information on this topic. In the 1980s, the Health Education Council (which became the Health Education Authority in 1987) had an advisory nursing group which commissioned a number of studies. One of these was a survey conducted to evaluate the health education component in nurse training (HEC 1980). The findings suggested there was little integration of the topic and that few nurse teachers were educationally prepared for that purpose. Most health education lectures were conducted by community tutors or health education officers. In order to address the gaps, a workshop was set up by the Health Education Council (HEC) in 1982. A select group of participants including students, teachers and service managers, were invited to attend. Recommendations for the teaching and learning of health education within nursing were made (Randell 1982).

Two major studies to investigate the nurse's role in communication and smoking advice were also commissioned by the HEC at this time. A series of studies and publications followed during the 1980s (Faulkner 1985, Macleod Clark et al 1985, 1987). These studies whilst adding to the body of knowledge on the nurse's role in health education especially in relation to smoking, emphasise an

individualised, lifestyle approach rather than a socio-political one.

When we surveyed the Project 2000 literature, we found that 'health' was not mentioned in the titles. A more specific search on 'evaluation' in relation to the integration of a philosophy of health into the curricula, showed that of the seven papers reviewed the majority were descriptive accounts. The papers did however, illustrate a general shift away from courses which emphasise hospitals and disease to people centred community care. Although this survey is by no way exhaustive, it is indicative of the lack of a research based curricular review in nursing and health studies and the urgent need identified by the English National Board, for such a study to be undertaken.

Evaluating Health Promotion and Health Education

There has been mainstream educational research using illuminative evaluation as a conceptual framework. When a nursing innovation in Australia was evaluated it was found that planning for subsequent semesters was made far easier following this type of evaluation (MacMillan 1987). College staff began to identify very strongly with the curriculum and became more innovative in their approaches to teaching in the clinical area.

Two linked concepts which the literature identifies as central to evaluating the impact of health education and health promotion in nursing courses are those of powerless and empowerment. Wallerstein (1992) reviewed the research literature and discussed her findings in relation to health promotion programmes. It was concluded that powerlessness or lack of control over ones destiny did in fact emerge as a broad-based risk factor for disease and empowerment, although more difficult to evaluate, was also demonstrated as an important promoter of health.

In Britain, these concepts, which developed from the work of Paulo Friere (1972) have been operationalised by Hopson & Scally (1981) and the Lifeskills projects, most usually used in schools, in learning disabilities units or in mental health situations.

A Department of Health funded study (Macleod Clark, Wilson-Barnett et al 1992) looked at the integration of health education and health promotion in nurses' practice in acute hospital ward settings and sought to determine factors for enhancing this aspect of the nurses' role. The study revealed that nurses' full potential was not being realised. Nurses on wards which practised primary nursing were most likely to integrate health education and health promotion into their role.

This study helpfully characterised the different approaches as:-

'Traditional approaches to health education and health promotion concern themselves exclusively with physical health, disease prevention, the individual in isolation from his/her environment and a 'top-down' approach to information and advice-giving. Alternatively, the more modern and enlightened approaches emphasise the promotion of positive health with physical, social and mental facets and an educational process that is collaborative and participatory. Concepts and values such as equity, collaboration, empowerment and multi-sectoral planning also underlie much of the current thinking on health education and health promotion'.

Since primary nursing encourages flattened hierarchies, holistic care and partnership between patients and nurses it can be seen why the integration of health education and health promotion is more likely on such wards.

In a study using illuminative evaluation, Meyer (1986) evaluated the development of a health promotion and health education course in basic nurse education. Meyer later presented her findings to a Health Education Authority organised conference on health promotion in medical education (Meyer 1988). A variety of methods were used to gather information and a national review of opinions was elicited. It was found by general consensus the health education input to pre-registration nurse education should: be threaded through the curriculum; be integrated with other subjects; explore wider social and political aspects; emphasise the community; explore learners' own values and attitudes; be taught with informal teaching methods.

One ambiguity exists however in relation to the general understanding of the word 'community'. When used by the nursing profession it is often used to refer to community nurses - nurses who do not work in institutions but who work essentially in exactly the same way as hospital nurses, on an individual basis with people who are being nursed at home.

Another interpretation of the term community refers to working with groups of people, who live close to each other, who share common interests and who may work together to further a common aim, usually in a social or political framework. It would seem important therefore when evaluating nursing curricula to ascertain which meaning was being proposed.

We return to the studies by Macleod Clark, Wilson-Barnett et al (1992) and Meyer (1986, 1988) in Chapter 4, where we discuss their role in our data analysis.

The questions which remain to be answered by research concern the effectiveness of the paradigm shift towards a philosophy of health, using methods which illustrate the process involved and the varying approaches to health education and health promotion produced.

The following aims and research questions were developed:

Aims of the Study

* This research project aims to develop a model for evaluation which can be applied to the health promotion component of any nursing, midwifery or health visiting curriculum. An illuminative evaluative approach was used.

* The purpose of the evaluation is to develop a framework to determine the extent and effectiveness of the health promotion component of these curricula, based on the concepts and principles recommended by the WHO in 1984 (see Chapter 4 and Appendix i).

* In-depth studies will be conducted on a range of pre- and post-registration courses in four centres. The studies will describe and evaluate how a philosophy of health has been implemented in relation to:

    the course objectives;
    curriculum content;
    teaching methods;
    organisation of learning;
    experiences/placements.

* Factors for and against the successful implementation of a philosophy of health will be identified according to the institutions, specialities and educational levels studied.

Research Questions

* How well does the structure and content of the programmes under study reflect the aims or principles of the curriculum ?

* Are the programmes in harmony with the internationally agreed guidelines on the concepts and principles of health promotion set out in 1984 by WHO ?

* What are the perceptions of course providers, course consumers, patients/clients and other nurses, midwives health visitors regarding the process and outcomes of implementing a programme based on a philosophy of health (including Great Britain. Statutory Instrument 1989, S.I. No. 1456, Rule 18A, see Chapter 4) ?

* By what criteria does the funding body (ie The English National Board) measure success?

CHAPTER 3

METHODOLOGY

The study was designed to enable the development of an evaluation approach which could be applied to any educational curricula for nurses, midwives or health visitors, to determine the extent and effectiveness of the health promotion component of their course. An illuminative evaluation, using case studies was therefore adopted.

Qualitative fieldwork was the dominant mode of enquiry which permitted a variety of perspectives to be identified and documented and the direction of the research to be influenced by data as they were collected.

We used a combination of approaches, methods and respondents referred to by Denzin (1970) as data triangulation. This concept has recently been discussed by Corner (1991) who states 'The use of triangulation of different methods and types of data within a simple study provides a richer and deeper understanding of the area under investigation than would otherwise be possible'. Triangulation enhances validity and reliability of findings.

Conceptual Model

The principal conceptual model which influences the design of our research is that of illuminative evaluation (Parlett & Hamilton 1977). This approach enables researchers to explore the educational process, programme outcomes and its consequences. Central to an understanding of illuminative evaluation are two concepts: The Instructional System and the Learning Milieu (Parlett & Hamilton 1977 p.10,11). The former is abstract (curriculum and associated documentation) and details of its implementation concerns the latter. In a curricular review there is a need to consider both elements of the curriculum because documentation is static, representing a specific point in time, whilst a study of the learning milieu demonstrates the curriculum in action.

Illuminative evaluations are considered to be problem centred and practitioner orientated in that they provide information for educators and are heuristically organised in that as the study progresses the researcher is able to progressively focus and re-define the areas of inquiry as crucial issues are uncovered (Millar & Parlett 1974).

The aims of illuminative evaluation are to study an innovatory programme; how

it operates; how it is influenced by the various school situations in which it is applied; what those directly concerned think of as its advantages and how students' intellectual tasks and academic experiences are most affected. It aims to document and discover what it is like whether as student or teacher (in our case this includes practitioners) to be participating in the scheme. It is looking for the innovation's most significant features and recurring concomitants and critical processes.

This approach enables the researchers to elicit interpretive descriptions of participants' experiences. It also emphasises the importance of identifying a plurality of perspectives in the process of constructing an understanding of the nature and quality of programme provision.

Evaluation using this approach concurs with Means and Smith (1988) who state that the 'success' or 'positive outcome' of an intervention may mean different things to different participants.

Green & Stone (1977) describe evaluation as "the systematic documentation of the consequences of programs and the determination of their worth in order to make decisions about them. Evaluation can be used to measure, prove, improve, judge, advocate and illuminate".

We combined our illuminative evaluation with a case study approach. Case studies are in-depth investigations of a person, group, institution or 'other social unit' (Polit and Hungler 1989). The case study approach was chosen to enable examination of 'A contemporary phenomena in its real life context, especially when the boundaries are not clearly defined' (Yin 1981).

The strengths of using case studies lie in the depth that is possible when using a limited number of people which permits the focus on individuals (Polit & Hungler 1989). This depth allows intimate information to be gained from accounts of the individual's actions, feelings, thoughts, intentions and environment, which was necessary when assessing Nursing, Midwifery and Health Visiting curricula.

The combination of illuminative evaluation and case studies, benefit from yielding data high in validity. Therefore more meaningful data will be generated to inform future research, policy and education (Whitehead and Tones 1991, Yin 1989, Huey-Tsey Chen 1988, Feuerstein 1986, Atkinson and Delamont 1986, Rippey 1973).

Key Methodological Issues

A major factor contributing to the lack of success of many evaluation programmes is the perceived threat to the participants, engendered by the situation.

This project determined from the outset to establish a working relationship founded on trust and confidence. It aimed to foster sensitivities developed by being evaluated and it utilised the concept of 'transactional evaluation' thereby diminishing the element of 'threat'.

Transactional evaluation provides an opportunity for participants to review and reflect on the evaluators' data and their interpretation of it. Our six month time scale limited the opportunities to do this.

We also incorporated Field and Morse's (1985, p.115) notion of the 'researcher-as-an-instrument' in recognising the key role of the researcher in promoting good rapport with participants and generating quality findings. The recognition that researchers' abilities and experiences are important in ensuring the amount and quality of data and depth of analysis is a key methodological issue in qualitative research. During data collection and analysis the research team drew on the following abilities and experiences:

The lead researcher's (SL) experience of designing and teaching a health promotion foundation programme for undergraduate nursing students (Lask 1991);

The same researcher's experience of 'being evaluated' in a participative evaluation of the above programme by an independent team of educational researchers;

The extensive experience of the research team in teaching a range of undergraduate, pre- and post-registration and primary health care programmes, including the Diploma in Higher Education (DipHE) (AM);

The researchers' experience in using qualitative (Smith 1992) and evaluative (SL) research methods.

In our efforts to ensure a rigorous approach to data quality and methods of data collection, the following approaches were taken:

* the data were selected systematically by the consistent application

of the instruments;

* these instruments were developed and members of the steering committee assisted in their validation;

* data were collected from a variety of sources to ensure a number of checks on accounts given by any one party (triangulation);

* data were usually collected in pairs and researchers debriefed following each data collecting episode;

* during data analysis, the researchers collectively discussed and commented on their emergent findings.

Reliability and validity of qualitative methods need to be seriously addressed and at all stages of the project the researchers were aware of the following issues:

* fittingness , which refers to the study's findings being able to "fit" into contexts outside the study situation and when, according to Lincoln and Guba (1981), the reader views its findings as meaningful and applicable in terms of their own experiences. In addition, the findings should "fit" the data from which they were derived;

* credibility is the criteria that apply to the truth value of the study and its applicability. If readers recognise the situation or experience when confronted with it after only having read about it, or if some are having the experience would recognise it from descriptions, the study is said to be credible and have construct validity;

* auditability is achieved when a clear decision trail is outlined by the researcher that can be followed by the reader, thus allowing him/her to follow the progression of events in the study while understanding their logic (Sandelowski, 1986).

Sample

A purposive sample was used for this qualitative study. A purposive sample selects settings and subjects identified by the researchers as being able to provide specific information and insights required for the study.

Four centres were selected because of the short duration and financial limits set out in the project specification.

Furthermore, this was a qualitative study which relies on in-depth data collection and analysis rather than the breadth required of a questionnaire survey.

The centres were selected according to the following criteria:

* Diploma in Higher Education (DipHE) established before 1990 (except one centre, see below);

* Post-basic courses - ENB 934 - The Care of People with HIV/AIDS and 1991 ENB Critical Care Course leading to ENB 100, 124, 176, and 182 plus the ENB 870 Introduction to Research Course and a Flexible Conversion Course from second to first level nurse.

Selecting post-registration courses allowed us to meet with qualified nurses from hospital and community who were beginning to experience the effects of implementing a philosophy of health in the field.

* Midwifery (Direct entry)

* The College/School of Nursing was associated with an Institution of Higher Education;

* The centres were representative of different geographical regions of England;

* In the first instance, DipHE Demonstration Sites were used to select the centres (see Appendix ii) because of their geographical spread and their success in being selected to implement a programme ostensibly based on a philosophy of health;

* We originally planned to select centres where the clinical environment was relatively stable, but found that this criterion was difficult to meet in all centres. The health service reforms and Working Paper 10 were impacting on both clinical and educational settings in terms of re-organisations, relocations and staff reprofiling.

* We consulted a fifth centre for the study of district nursing and health visiting as these programmes were not available at our four original centres.

The following centres were selected. For reasons of confidentiality the actual names of the Centres are replaced by the letters A,B,C,D and E. The site/campus names are pseudonyms.

Institute of Health - Centre A
DipHE Course, ENB 870 and Flexible Conversion Course from second to first level nurse;

College of Health - Centre B - West Campus
DipHE Course and Flexible Conversion Course from second to first level nurse;
College of Nursing and Midwifery - Centre C
DipHE Course, Direct Entry Midwifery and ENB 934 Course - Caring for People with HIV/AIDS;

College of Health - Centre D - South site
DipHE and a range of critical care post-registration courses (Intensive Care, Critical Care, Theatre Nursing, Anaesthetics, Accident & Emergency Nursing: 100, 124, 182, 199 and 176).

The DipHE programme running at this Centre was not established until 1991. During our preliminary enquiries, we found that many of the first wave demonstration sites had already been well exposed to evaluation and research. We decided therefore to take one centre where this was not the case. We also considered it a good opportunity to find out if a third wave DipHE programme had benefited from the experiences of a demonstration site close by.

School of Health Studies at the **'New'** University - Centre E

District Nursing and Health Visiting Programmes.

Due to time constraints we undertook a consultancy at Centre E rather than a full case study.

At each of the case study centres, the final selection of staff and students available for participation in our study varied. We asked to meet a selection of lecturers from each theme team or specialty, as well as those specifically responsible for teaching 'health' and student placements. We also asked to meet representatives from the local health promotion unit and clinical staff from hospital and community. The College Principal designated a staff member to liaise with us. The final selection of participants in the case studies reflects our orientations, the designated staff member's perceptions of the project and the willingness and availability of individual teachers, students and clinical staff to

participate during the data collection period.

The numbers and type of participants involved in the study are summarised below, according to the instruments used.

Data Collection Methods

The educational institutions for the study received:

1. An explanatory letter/telephone call inviting them to participate;

2. A preliminary visit to meet the College Principal;

3. A four-six day visit for intensive-data collection;

4. Opportunities to comment on interpretations from the data.

Seven main features of data collection included:

1. Documentary analysis.

   Course Outlines and curriculum documents were examined to elicit the stated intentions, aims and proposed educational practices.

   Assessments and outcomes of the courses were also examined.

2. Semi-structured interviews with course providers.

3. Semi-structured interviews, questionnaires, focus discussion groups with course consumers i.e. students.

4. Semi-structured interviews with two representatives from the funding body.

5. Classroom observations.

6. Semi-structured interviews with qualified practitioners.

7. 'Back of the shop activities' e.g in coffee rooms and car journeys.

During the preliminary phase the interview and observation schedule and

questionnaire formats were devised and piloted in an educational institution not for inclusion in the study.

Our data collection methods and the time frame within which we worked are summarised in the diagram at the end of this chapter.

Instruments

Four Instruments were used including

(a) semi-structured focused interviews for lecturers, practitioners and others for example, practice nurse co-ordinators or health promotion officers (see Appendices v,vi,vii);

(b) classroom observation record (see Appendix viii);

(c) focused discussion groups, used with

(d) an open ended questionnaire (see Appendices ix and x).

(a) Semi-structured Focused Interviews

The main purposes of interviewing people is to find out those things that cannot be observed, allowing entrance into another person's perspective (Merriam, 1988). Interviews allow insight into feelings, concepts, likes and dislikes. Focused interviews are useful to find out how the respondent defines certain situations and allow issues previously highlighted to be explored, while unstructured interviews are useful when the aim is essentially exploratory and there is a need for new information to emerge.

Semi-structured focused interviews were used in this study, a range of questions were developed, derived from previous research studies, Aggleton et al (1989) and Meyer (1986,1988) and from tape recorded focused interviews held with a small group of qualified nurses on a postgraduate Masters and teaching courses.

Certain areas were noted for inclusion in the interview, but each interview took its own course depending upon the perspective of the interviewee.

Each interview was tape-recorded and lasted from between 45 minutes to 1 1/2 hours. Two researchers took part in the interview, one to lead the discussion

and the other to take notes.

Following every interview the researchers debriefed and made joint notes on the main features of the outcomes. Transcripts were made and their content analyzed for themes and concepts.

The following numbers and types of participants were involved in interviews and discussions:

Centre A

12 interviews : 13 participants

* Mental Health Tutor
* Head of Department - Post-basic
* Lecturer - health promotion
  plus student representative (Drama Group)
* Head of Branch - Adult
* Lecturer - assessment
* Clinical Tutor
* Lecturer - health promotion
* Lecturer - Physiology
* Programme Director - FCC
* Head of Mental Health and Learning Disabilities
* Ward Sister
* Community liaison nurse at the Health Promotion Unit

3 discussions : 14 participants

Two students in the learning disabilities branch programme; three students taking the Flexible Conversion Course (FCC); and nine post-registration students taking ENB 870 Research Appreciation Course.

Centre B

13 interviews: 14 participants

* Curriculum Manager
* Learning Disabilities Lecturer
* Senior Education Manager (SEM) Community and

Health Team Leader
* SEM Child
* Lecturer - Mental Health
* SEM Adult
* SEM CFP
* Lecturer - Sociology & Biology
* Lecturer - FCC
* Health Promotion Unit Officer
* Registered/enrolled nurses (3) - acute medical ward

1 discussion: 12 participants

Twelve participants in one Health Centre, including seven district nurses, four health visitors and one community clinical nurse specialist.

Centre C

11 interviews:15 participants

* Lecturer - HIV/AIDS course
* Senior Lecturer - Health Promotion
  and Lecturer - Nursing
* Cohort Leader - Branch,
  Lecturer - Sociology and
  Lecturer, Health Promotion - Adult Branch
* Lecturer - Mental Health
* SEM, Research & Development
* Two Midwifery Lecturers
* Researcher - Health Promotion Unit
* Clinical Nurse Specialist
* Researcher - Heart of the City project
* Lecturer - Sexually Transmitted Diseases Courses
* Lecturer - Common Foundation Programme

2 discussions: 20 participants

Twenty post-registration students from acute nursing, midwifery, hospital and community settings, undertaking the HIV/AIDS course, in two groups of ten.

Centre D

5 interviews: 6 participants

* Lecturer - Common Foundation Programme (CFP)
* Librarian
* Two Lecturers - CFP and Adult Branches
* Health Promotion Unit Officer
* Practice Nurse Co-ordinator

3 discussions: 32 participants

Eight lecturers, from critical care post-registration and Midwifery education, CFP, Adult, Mental Health Branches, one librarian.

Three lecturers - post-registration critical care course (also participated in above discussion); post-registration A/E course; post-registration Operating Theatres course and ten post-registration students from corresponding courses.

Eight students from the DipHE Branch programmes (five from Adult and three from Mental Health Branches)

Three registered nurses from one hospital medical ward

Centre E (Consultancy)

2 interviews: 2 participants

Head of Department - Health Studies
Health Visitor Lecturer

(b) Classroom Observations

The purpose of observing classes was to ascertain the relationships between staff and students and to gauge the academic and cognitive levels reached. Content was also important. Although we did not specifically ask to observe a class labelled 'health' or 'health promotion or health education', we were usually directed to health related classes.

The instrument which the research team used was developed from an amalgamation of teaching assessment forms. Each observation was recorded on the form by two researchers who then debriefed and made notes on their

conclusions, impressions and outcomes.

The following classes were observed:

Centre A

Mental Health class on child abuse

Centre B

Two psychology sessions in Term 8 Adult Branch

Centre C

Two classes: one on the post-registration HIV course on spirituality and the other a class for midwifery students on the psychological effects of surgery.

Centre D

One class in Unit 2 on Children with Special Needs and the conclusion of a revision session on the nervous system for DipHE students at the end of CFP.

(c) Focused discussion groups and (d) open ended questionnaires

Two different questionnaires were created: Form A (Appendix ix) and Form B (Appendix x).

They were designed to be completed either individually or in small groups or to be used as prompts for group discussion. There were also opportunities on the form for open-ended comments. One researcher led the session and the other took notes. The discussions were tape-recorded.

Form A was designed using ideas from a similar study (Aggelton et al 1989).

Questions were included to:

1. Ascertain the respondents' general understanding of the concepts of health promotion and health education, so we could determine which theoretical models were taught and used by the students;

2. Look at how much the college had influenced the student and attempt to determine whether changes in perception were occurring;

3. Questions 3 and 5 attempted to elicit whether the students were able to apply theory to practice;

4. Questions 4 and 5 sought to determine the range of role models the students had been exposed to and also to see if they had a vision of a future health promotion role;

5. Self-awareness was considered an important prerequisite for a health promoter and Questions 6 and 7 looked at students' personal awareness and strategies for promoting their own health;

6. The integration of the concept of health into nursing and allied topics was explored in Questions 8 and 9. Question 9 took a light hearted approach to round off the demanding questionnaire.

Form B took a completely different approach. It was an adapted extract based on Drew's (1988) satirical piece on the influence of the social sciences and health promotion on nursing and the subsequent demise of the biological sciences. By taking a devil's advocate role it was intended to provide an opportunity for those who were not supportive of the health promotion role of nurses to express their opinion. The extract was followed by a short series of questions.

The decision to use this format was taken following a focus group discussion with Masters and teaching students during the pilot phase of our study. It became evident that not all participants agreed with basing the curriculum on a philosophy of health. Using a questionnaire that played devil's advocate allowed respondents to present all sides of the argument. The technique of using questionnaires during focus groups is derived from the work of Stewart and Sham Dasani (1990).

The questionnaires were distributed to the following groups in each centre, followed by a focus group discussion.

Centre A

One group of 20 Common Foundation Programme (CFP) Students:

12 completed Form A and 8 completed Form B.

Centre B

Three groups of CFP students with 16,11 and 13 in each group:

32 completed Form A and 8 completed Form B

Centre C

Two groups of CFP students with 19 and 18 students in each group.

15 completed Form A and 22 completed Form B.

One group of Direct Entry Midwifery students. 10 students completed Form A only.

Centre D

One group of 28 CFP students. Only Form A was distributed and completed.

Note on Response Rate: All students present in the class on the day of the research completed the questionnaires and participated in group discussion. The only exception was the Midwifery group in Centre C. Three students left the session because of prior commitments without completing the form.
Because students found difficulty with Form B we distributed fewer questionnaires using this format.

The questionnaires were analyzed by the researchers using the following framework: (a) attitudes, motivation and enthusiasm towards the topic and length of answers; (b) knowledge of health promotion/health education models, theory of approaches; (c) own reported behaviour or cognitive changes; (d) the integration of their approach with their concept of nursing practice; (e) how appropriate their response was in relation to the philosophy of health in operation at their centre.

The taped discussions were transcribed and analyzed for themes and concepts.

In summary, throughout the data collection researchers wrote fieldnotes whilst in the research setting and debriefed regularly on their observations and insights. Collecting data in pairs enhanced validity and reliability.

Data Analysis Techniques

Our strategies for handling, managing and coding data from interview and field settings were informed by qualitative researchers such as Glaser and Strauss (1967) Field and Morse (1985) Riley (1990).

These strategies assist the researchers to develop conceptual categories and formulate hypotheses from recurring themes to inform ongoing data collection, analysis and generate findings.

Once data collection was complete we continued to meet at regular intervals to discuss our analysis and proposed findings.

Consultations

Various professionals associated with nurses, midwives and health visitors were consulted as part of this project and their comments have been integrated throughout the report.

Jenny Moon, a health promotion adviser for Wales based in Cardiff, gave us helpful information regarding perceptions of the nurses' role in health promotion.

Sue Latter at Normanby College, who was on our Steering Committee, discussed methodological issues with us.

Val Levy, a Principal Lecturer at the IANE, RCN helped us with issues relating to Parentcraft Classes in Midwifery.

Study Limitations

It would have been interesting and beneficial to have included some DipHE diplomates in our study, as we were always studying 'the unfinished product'.

Form B (appendix x) did not work as well as intended. None of the students saw the irony of the piece. This may have been because the students were in

Common Foundation Programmes with limited clinical exposure. It is possible the format would have been more successful with senior students.

Access to the curriculum documents was variable. In some centres we were given them to take away; in other centres we were able to study them 'on site' but there were also some curricula which were not released for our use. When this situation arose we obtained permission to examine the documents in the ENB's archives. Even so, a number of curricula were in use elsewhere throughout the duration of the project. This can be a problem in a short term study when time is at a premium.

The short time scale of our research also limited the participants' opportunities for feedback. Illuminative evaluation depends on an open and collaborative relationship between participants and researchers. We found however that occasionally students in particular had not been adequately informed or consulted about their inclusion in the study. In illuminative evaluation, continuous efforts are required by the research team to ensure all participants, students as well as staff, are part of the negotiation process. It is possible that a six month research contract is too short to permit 'meaningful' collaboration, transactional evaluation and feedback in the time available.

Data Collection Process

1. Preliminary Telephone Call

2. Introductory Letter
+
follow-up telephone call confirming preliminary visit
project outline and WHO(1984) document sent
APRIL 1993

3. Preliminary Visit
2/3 researchers to visit Principal
APRIL 1993

4. Data collection Visit
4-6 days includes:
* semi-structured interviews with college staff, practitioners and students
* focus group discussions
*classroom observations
*documentary analysis

Lecturers debrief

JUNE/JULY 1993

5. Interpretations and findings sent for comment and feedback
DECEMBER 1993

CHAPTER 4

INTRODUCTION TO FINDINGS

Details of each centre's findings are found in stand alone case studies (Chapter 5-8) and one consultancy report (Chapter 9). The centre studies are followed by Chapter 10 which summarises the key research findings. As stated above, the centres' proper names are replaced by the letters A, B, C, D and E. Site and campus names are replaced by pseudonyms.

Analytic Frameworks for the Findings

Our findings are organised to correspond with the illuminative evaluation framework proposed by Parlett & Hamilton (1977). Each case study is divided into two sections i.e. the Instructional System which comprises the written documents and the Learning Milieu which we explored using interviews, discussions, questionnaires, classroom observations and 'back of the shop activities'.

The Instructional System

Curriculum documents were analyzed for their intentions, aims and proposed practices. Reading lists, timetables and assessment criteria were examined.

Throughout our analysis we aimed to answer the following questions:

1. What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents?

2. To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application as contained in timetables and placement information?

3. How was the course assessed and outcomes described on what basis was the 'success' or 'outcomes' of the curricula judged?

The Learning Milieu

We formulated the following research questions during the analysis of data from

interviews, discussions, student questionnaires, classroom and general observations .

* What is a philosophy of health?
* Is looking at health first the 'right' approach?
* Preparation for a philosophy of health within the curriculum.
* The 'hidden curriculum'. How healthy is the learning and working environment?
* Integration of a philosophy of health into theory and practice.
* Powerlessness and empowerment in the context of change.

We used the following criteria to assess how well the programmes were working:

* Comparison of curricula intentions, aims, objectives and proposed practices with what we observed and the participants' accounts.

* Comparison of our findings with the UKCC recommendations in Project 2000: A New Preparation for Practice and summarised below (UKCC 1986).

The Project 2000 DipHE Course philosophy states that throughout the three year programme, students will develop cognitive, affective and psychomotor skills which underpin the UKCC 13 outcomes as stated in statutory instrument No.1456, Rule 18A (Great Britain.Statutory Instrument 1989) presented below.

STATUTORY INSTRUMENT NO. 1456, RULE 18A

(1) The content of the Common Foundation and the Branch programme shall be such as the council may from time to time require.

(2) The Common Foundation Programme and the Branch Programme shall be assigned to prepare the student to assume the responsibilities and accountability that registration confers, and to prepare the nursing student to apply knowledge and skills to meet the nursing needs of individuals and groups in health and in sickness in the area of practice of the Branch Programme and shall include enabling the student to achieve the following outcomes:-

(a) the identification of the social and health implications of pregnancy and child bearing, physical and mental handicap, disease, disability, or ageing for the individual, her or his friends, family and community;

(b) the recognition of common factors which contribute to, and those which adversely affect, physical, mental and social well-being of patients and clients and take appropriate action;

(c) the use of relevant literature and research to inform the practice of nursing;

(d) the appreciation of the influence of social, political and cultural factors in relation to health care;

(e) an understanding of the requirements of legislation relevant to the practice of nursing;

(f) the use of appropriate communication skills to enable the development of helpful caring relationships with patients and clients and their family and friends, and to initiate and conduct therapeutic relationships with patients and clients;

(g) the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion;

(h) an understanding of the ethics of health care and of the nursing profession and the responsibilities which these impose on the nurse's professional practice;

(i) the identification of the needs of patients and clients to enable them to progress from varying degrees of dependence to maximum independence, or to a peaceful death;

(j) the identification of physical, psychological, social and spiritual needs of the patient or client; an awareness of values and concepts of individual care; the ability to devise a plan of care, contribute to its implementation and evaluation; and the demonstration of the application of the principles of a problem-solving approach to the practice of nursing;

(k) the ability to function effectively in a team and participate in a multi-professional approach to the care of patients and clients;

(l) the use of the appropriate channel of referral for matters not within the sphere of competence;

(m) the assignment of appropriate duties to others and the supervision, teaching and monitoring of assigned duties.

The competencies are broad and demand a programme that will facilitate the student to make connections between health and society, politics and culture, use literature and research, emphasise communication, view the patient/client holistically throughout the life cycle and work in multi-disciplinary teams.

The 1986 UKCC guide-lines (1986) stressed that the Common Foundation Programme must be 'embedded in health not in illness'(p.46) and that the students must learn about normal living and appreciate that care is not always about practical activities. Placements were to be wider than traditional community placements including the work place.

A recommendation for shared learning with other health care professionals was included. Also that each practitioner should be able to practice in a variety of settings and have an awareness of a broader range of health and healing than traditionally found in hospitals.

Recommendation 22 suggests that 'joint professional and academic validation should be pursued'.

* Comparison of our findings with the WHO discussion document on the concepts and principles of health promotion (WHO 1984)

We looked for evidence of the five principles summarised from the 1984 WHO document below.

(i) Opportunities for students to enhance their own health by strategies such as relaxation training, stress management skills, complementary therapy, sports facilities, communication, general and time management skills, union involvement and religious observance.

(ii) Holistic and diverse approaches aimed at enhancing and promoting health and wellbeing.

(iii) Knowledge and skills enabling students and their patients/clients to engage in community participation such as assertiveness skills, networking with voluntary and statutory agencies.

(iv) Evidence of knowledge in the social and behavioural sciences

(v) Evidence of skills in health education and health advocacy

We found limitations in our original criteria for assessing how well the programmes were working particularly in relation to the WHO health promotion document (WHO 1984). We decided therefore to consult recent research in the field (MacLeod Clark, Wilson-Barnett et al 1992, Meyer 1986,1988).

Macleod Clark et al (1992) give a useful definition of the different approaches to health education and health promotion which we found useful for our analysis.

'Traditional approaches to health education and health promotion concern themselves exclusively with physical health, disease prevention, the individual in isolation from his/her environment and a 'top-down' approach to information and advice-giving. Alternatively, the more modern and enlightened approaches emphasise the promotion of positive health with physical, social and mental facets and an educational process that is collaborative and participatory. Concepts and values such as equity, collaboration, empowerment and multi-sectoral planning also underlie much of the current thinking on health education and health promotion'.

Meyer (1986,1988) developed a consensus view based on expert opinion of what health promotion within nursing education should be:

* threaded through the curriculum;
* integrated with other subjects;
* explore wider social and political aspects;
* emphasise the community;
* explore learners' own values and attitudes;
* be taught with informal teaching methods.

We used these research studies to assist in organising and interpreting our data and inform our analysis.

Introduction to Case Studies

Each centre provided us with a rich source of data illustrating differing and varied interpretations of the integration of a philosophy of health into the educational curriculum of nurses, midwives and health visitors. We were warmly welcomed and participants were extremely generous with their time. During fieldwork a portrait of the college developed through the various data collection methods used.

The research team found using an illuminative evaluation enabled them to gain insights into each centre's 'story' of integrating a new programme based on concepts of health. We do not attempt to compare centres but use the similarities and differences found to illustrate the issues pertinent to a curricular review for the education of the professions. The case studies offer an indepth picture of the change process which is taking place in colleges throughout the country.

We re-emphasise we regard a curricular review to comprise the two elements of illuminative evaluation i.e. the Instructional System (documentary analysis) and the Learning Milieu (empirical data in the settings where the curricula are being implemented). In this way we could gauge the 'fit' between the written and 'living' curriculum by applying a dynamic rather than a static approach to its evaluation.

The Curriculum Documents

The structure and content of the curriculum documents in the centres were all different. Our access to them was variable ranging from being given them to take away, to studying them on site, to them not being available at all. The teaching staffs' hesitation in releasing the documents may have been associated with an unexpressed fear of plagiarism and competition.

Presentation of the Case Studies

In the main, we use the language of the centres as contained in the curriculum documents and as spoken by respondents during observation, interviews and discussions. For example, the Diploma in Higher Education (DipHE) was popularly referred to as 'Project 2000'.

In both sections of the case studies interpretative commentary intersperses the findings with researchers' insights and descriptions of participants' experiences in the spirit of the researcher-as-an-instrument. In this way, we construct an understanding and interpretation of the nature and quality of programme provision by telling peoples' stories and describing their accounts in order to develop a picture of the reality of what is happening for them.

As an aide-memoir to the reader, the data sources from which the findings are derived are summarised in the diagram below.

SUMMARY OF DATA COLLECTED

DATA SET	CENTRE A	B	C	D	E
*Interviews	12	13	11	5	2
N	13	14	15	6	2
*Discussions	3	1	2	3	-
N	14	12	20	32	-
Classroom Observations	1	2	2	2	-
Questionnaires					
N	20	40	47	28	-
Total Group N	1	3	3	1	-
Form A	12	32	25	28	-
Form B	8	8	22	0	-
Group Discussion	1	3	2	1	-

* Teachers, College support staff, pre- and post-registration students, Health Promotion Officers, community and hospital practitioners took part in the interviews and discussions. Details of participants in each centre are contained in Chapter 3 and the respective case studies.

CHAPTER 5

CENTRE A - INSTITUTE OF HEALTH

OVERVIEW AND ORGANISATION OF FINDINGS

The Institute of Health is based in refurbished buildings on the site of a Psychiatric Hospital. A few wards still remain in use for patients with learning disabilities and mental health problems. There has been an 'educational presence' for mental health nurse training on this site for a long time. In the mid seventies, the School of Nursing amalgamated with a general training school and the Institute was formed in 1986 with the appointment of a new Director.

The college now comprises two large buildings set in beautifully landscaped grounds, on the outskirts of a large town and 15 minute drive from the General Hospital in the town centre.

There has been recent expansion and extension of buildings, including new classrooms funded from income generated from the Continuing Education department.

A large lecture hall has been provided along with several large classrooms and a few smaller seminar rooms. Two to four lecturers share newly decorated offices depending on the size of the room. Team leaders have their own offices and many lecturers have the use of a personal computer. A small kitchen is available for staff to make coffee and snacks and a large coffee room with easy chairs and a vending machine is provided for students.

The hospital canteen is close by. The food on site is cheap but there does not appear to be a particular emphasis on healthy eating.

All the offices and the classrooms have been tastefully refurbished. Aspects of one building are especially delightful, with listed architectural features and objects d'art. It is a peaceful and pleasing environment in which to work, with only the occasional interruption from the hospital siren alerting the 'escape' of one of their more challenging clients.

An information technology laboratory with a variety of Computer Assisted Learning (CAL) packages is available, as is a large spacious and well stocked library. The library has CD ROM and some on-line data base facilities. Health or health promotion is not treated as a special topic and the Senior Librarian

indicated that funds had not particularly been allocated to health. She did however emphasise that the students used the well stocked resources centre at the Health Promotion Unit in the town and that the subjects aligned to health - sociology, politics and psychology were well stocked and had been recently improved.

An Occupational Health Service and a part-time counselling service are available for students.

A well used reprographics and printing resource is on-site, which produces numerous, successful income generating programmes.

There are several subject specialists on the staff who are non-nurses and who have linked posts with the local University. There is also a team of researchers, some of whom are non-nurses.

The local Health Promotion Unit provide an active and innovative programme on health related study days and short courses. These are attended exclusively by qualified nursing staff. However, the Unit has been working collaboratively with one group of creative pre-registration students, in developing a health promotion drama group which visits local schools.

Teacher profile

There are 80 teachers on the staff, most of whom have relatively new appointments. The Learning Disabilities team has lost a large proportion of its members recently. Most of the staff have first, if not second degrees and some are studying for degrees at present. There was a general feeling that staff had been very well supported recently in furthering their education. Several teachers are currently studying for an MSc in Health Education and related topics. These teachers are currently involved in the health and health promotion teaching, although they were not part of the curriculum design team.

Student intake and characteristics

Detailed statistics on post-registration students were not available from Centre A. Current numbers of the Diploma in Higher Education (DipHE) students are:

Adult Branch	300
Child Branch	30
Mental Health Branch	112
Learning Disabilities Branch	70

Demographic details were not available but from observation the majority of students were in their early twenties, female and white.

Main overview of findings

Centre A was within daily travelling distance for the researchers and so data collection was arranged for 4 consecutive days in one week and two further individual days.

The following data were collected:
In-depth interviews from:

The head of the Mental Health Branch
The head of Post basic Education
The head of Adult Branch
A senior tutor involved with assessment
A tutor with a special commitment to health promotion
A physiology lecturer
The Programme Director for the Common Foundation Programme
A Mental Health tutor
A tutor and a student representative involved in a health promotion initiative;

We had an interview with a Ward Sister at the local General Hospital and an interview with a community liaison nurse who worked at the Health Promotion Unit.

We were able to observe only one class (in the Mental Health Branch) but we had focused discussions with groups of post-registration students on the Flexible Conversion Course (second to first level nurse) and the ENB 870 Research Course.

Two groups of DipHE students participated in the research. We interviewed representatives from the Learning Disabilities Branch and we had group discussions with and questionnaires were completed by October '92 students

During the week we were at Centre A the DipHE students were hosting a Health Fair as part of an assessment.

THE INSTRUCTIONAL SYSTEM

The DipHE curriculum at Centre A is a joint document produced by the Institute of Health and the local University.

On successful completion of the programme, students are awarded a Higher Education Diploma in Nursing Studies with Appropriate Registration in one of the Branch specialties.

Three curricula were examined as part of this study.

1. DipHE, Common Foundation Programme and all four Branch Curricula: Adult; Child; Mental Health and Learning Disabilities.

2. The E.N.B. 870 research course.

3. A flexible conversion course; a part-time course for qualified State Enrolled Nurses to convert to Registered Nurses (second to first level nurse).

THE CURRICULA

What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents?

The school philosophy consists of 14 issues which include concepts related to personal development, the social construction of the environment; motivation towards enhancement and learning and the uniqueness of human beings.

The philosophy addresses health, illness and nursing - 'nursing is seen as a service which strives to promote, maintain or restore health of individuals, families and communities whose self-care capacity is at risk or diminished'.

Adult learning principles are included, as are notions of equality of opportunity.

The curriculum involved sequential continuums in both broadly applied nursing principles and detailed nursing specifics. It is learner-centred and promotes problem solving and human needs concepts.

Nursing models are utilised to promote critical analysis and understanding of nursing based on relationships between practice, theory and research.

Concepts of specialisation and clinical access among nurse teachers are fostered.

The curriculum represents a broad, thorough, well conceived, erudite approach which potentially encompasses the components to deliver a curriculum embedded in concepts of health.

Course philosophy and rationale

Nursing in the curriculum is considered as a process which promotes optimum health through pro-active and generative behaviours at interpersonal and community levels.

The approach used states that 'it is a departure from the traditional dualistic or 'medical model' of caring, which divides man into mind and body and explains and cares for him on disease orientated principles'.

The UKCC principles are evident as the curriculum is embedded in health and normal functioning. The new philosophy of health forms the linchpin of the new curriculum.

The course is based on six units of humanistic, holistic and integrated concepts of nursing theory and practice:

Unit 1 Introductory component and 'Lifestyles';
Unit 2 Maintaining health and preventing ill health;
Unit 3 Learning to care;
Unit 4 Participant observer;
Unit 5 Participant observer/participant (rostered);
Unit 6 Participant (rostered)/evaluator (synthesis).

All Units embrace five core themes from the 1989 ENB guidelines:

1. The person/individual; 2. Society; 3. Health; 4. Health care;
5. Nursing.

There is an emphasis placed on positive health which is cross-referenced with the effects of handicap, loss and illness. Health education is introduced during the first year and applied to the role of the nurse in the care of age groups during the second and third years. Evidence that a philosophy of health has been used as the framework for the curriculum is clear.

To what extent is a philosophy of health integrated within the curriculum as evidenced by theoretical content and practical application?

The spirit of the WHO 1984 document is not directly represented but is reflected through references to developing a broader conceptual approach for nurses. Political and sociological aspects are evident.

The curriculum has been developed using aspects from the following four models:

Bruner's Spiral Curricular Process and Mastery of Learning;

Skilbeck's model of situational analysis;

Roger's concept of being 'free to learn';

Knowles' approach to andragogical learning and experience.

The Common Foundation Programme uses a developmental approach with socio-political perspectives and takes into consideration the fact that contemporary Britain is multi-cultural and multi-ethnic. Emphasis is placed on race, ethnicity and social class. It is focused in the caring process.

There is also a stated commitment to an integration of the following issues:

* Health education
* Individual needs
* Decision-making
* Nursing models and process
* Research
* Professional development
* Role of nurse
* Development of specialist nurse

Health education appears as one of eight issues which is to be integrated throughout the Common Foundation Programme.

Each unit takes a biological, psychological, sociological and nursing perspective.

For example, in Unit 1, week 1 is structured as below:

	Monday	Tuesday	Wednesday	Thursday	Friday
am					
	Nursing	Biology	Psychology Models of Man	Sociology Man and Society	Tutorials
pm					
	Communi-cation	Study Skills	Research	Tutorials	Study Skills

The focus in this unit is the study of normal 'man' and behaviour. Each discipline is taught without reference to disease or the nursing care of people with various illnesses or conditions.

The courses are shared by the various subject specialties. For example, the first one and a half hours of a topic might be taking a psychological or sociological approach and the second half would be looked at from a biological perspective.

Week 24, for example, is concerned with the development of sexuality in adolescence - again a bio-psycho-social approach is indicated and strategies for promoting health might well be included, depending on the interest and motivation in health promotion of the individual lecturer. The 'marriage' of these disciplines does not always appear to be a happy one. For example, in week 25, there appears to be the first overt reference to gender issues. The first half of the session is entitled 'gender, sex roles and the development of self-concept'. The second half is concerned with 'The carriage of respiratory gases and the body's response to a need for oxygen'.

The potential advantage in using this approach is that nursing is perceived in a holistic way and the students learn to fully integrate knowledge from each approach and apply it to their future practice. Possible problems include the students' failure to develop a clear understanding of each disciplines world view and that their learning becomes fragmented.

Unit 1 is concerned with developing foundation skills in the students of communication, study skills and an introduction to normal body physiology, normal behaviour and an introduction to studying western British culture from a sociological perspective.

Each unit lasts approximately 26 weeks. In each unit there is an opportunity for

students to negotiate elective studies in the following: drama; music; yoga; sport; languages; bio-psycho-social science.

It is not until Unit 2 that a health promotion/health education focus is emphasised.

Week 1 is entirely concerned with health promotion

This emphasis on concepts related to health continues throughout the unit. Weeks 7, 8 and 10 are spent on a network project. From Week 13 to Week 21, students do clinical placements for 4 days each week with various community health care workers; health visitors, district nurses, community psychiatric nurses, community nurse for the mentally handicapped, a Social Services placement, a health centre placement, residential care of the elderly and voluntary services placements.

Week 22 is totally concerned with a philosophy of health and health education and Week 23 is completely devoted to health education.

In the sociology course in this Unit, there are many opportunities to develop the students' abilities and knowledge related to health, with sessions like, the nature of society, power, authority and status, wealth and poverty, role of the father and other family members during childbirth, societal attitudes towards childbirth, including caesarian section, transition to parenthood, education in Britain, poverty, social class and ill health with reference to women, ethnic minorities, the Black Report.

The one session directly related to health promotion is entitled 'Prevention, Health Education as Health Promotion - potential strategies for the prevention of disease and the promotion of health.'

If the lecturer is committed to developing the nurses' role in health promotion and identifies and emphasises in each topic what is relevant and appropriate for the integration and development of the student, then the opportunities for health promotion will be maximised.

In Unit 3 the focus on health promotion/health education does not continue. The only emphasis on a philosophy of health occurs in Week 17. The following topics are allocated in 7 x 2 hour periods:

The nurse as health educator - ante natal care, mother or foetus? ; the paediatric nurse as health educator; the school nurse as health educator; health education

and adolescence; the hospital nurse as health educator; is the district nurse the new community educator ?

Computing, by comparison is allocated 6 x 2 hour periods, which indicates that health education in this Unit, is not given a particularly large weighting - only 2 hours more than computing and only for one week out of 26.

This Unit has no other direct references to topics labelled health promotion or health education in it at all. However, there are many facets of the topic included under nursing topics: ethics; communication; health and safety at work; citizens' rights; lifting techniques; negotiation; counselling; education; holistic approaches and therapeutic models.

How was the course assessed and outcomes described?

During Unit 1 the clinical placements are to do with exposing the students to 'normal society' as the UKCC (1986) suggests. The students spend one week on a neighbourhood study/profile, where they document the characteristics of their local environment: a child study for 3 individual days; a 6 day family study and a one week work placement.

The theoretical assessment involves a lifestyle project, associated with the neighbourhood profile. The scope of this project, it appears has been reduced, as the students now apparently have to confine themselves to the college, which must seriously inhibit their potential for learning.

In Term 2, where the focus is predominantly on concepts of health and health promotion the assessment is the health education/health network project which is described thus: 'This project seeks to promote an understanding of the health education/health network component of the holistic nature of man in society'.

There are three aspects to this assessment. Firstly the clinical placements which involve 4 days per week during the majority of the unit with a wide range of community nursing staff and one placement in a social services or voluntary sector establishment. Secondly, the students are required to present a seminar paper to their peers on an aspect of the practitioners role, either from the perspective of the client or the practitioner. Emphasis is usually on aspects of liaison and access, so the student develops a picture of how the community nursing network functions. Finally, the students hand in a written paper reflecting on their presentation skills of the seminar.

The students have an identified practice supervisor for Units 1 and 2. The preparation and evaluation of these supervisors are not formalised. However, considerable time is spent in informal discussions and liaison. From Unit 3 onwards the supervisor is more likely to be a nurse with ENB 998 qualification.

The theoretical assessment for Unit 3, the final Unit in the Common Foundation Programme is an essay on models of nursing. The students undertake clinical placements in hospital units.

The assessments of the clinical or field placements do not especially seek out health promotion skills in the students, although they are written flexibly which could allow for an interpretation which encompasses health promotion. There is no overt reference to the topic.

BRANCH PROGRAMMES

These are designed to extend and broaden the 'core themes' from the Common Foundation Programme. All Branches meet regularly for study days of common studies to include computing, ethics, communication and nursing. For example in Unit 4 the common studies include assertiveness training and pharmacology, in Unit 5 teaching skills, communication skills, Makaton and Bliss and in Unit 6 for professional issues.

There are no common studies directly related to concepts of health or health promotion. However, if the ethics, communication, assertiveness and teaching had the health promotion components emphasised, or the sessions were re-labelled health promotion, then this opportunity for consolidation and integration would be maximised.

The Child Branch

The aim is to produce nurses who are enquiring, forward thinking, research minded, knowledgeable professionals, seeking to achieve the highest possible standard of care for children and their families in a variety of care settings.

It is possible that health promotion/health education can be subsumed under 'standards of care' but it would be preferable to see this aspect of nursing clearly stated. The aims also take an individualistic approach.

Four main themes provide the framework for learning.

1. Personal and professional development of the individual.

2. The child as a developing individual.

3. Health and health care.

4. Society.

It is Theme 3, health and health care where components of health and health promotion are placed and here only minimal overt reference is made. The content tends predominantly to fall into medical, preventive approaches. In Unit 6, one of 10 study days/tutorials is called the nursing process in health education.

The Adult Branch

The study of the concepts of the individual, society, health care and nursing care continues and is applied to the nursing care of adults. The core elements are continued. Health education is one of eleven themes. There are many opportunities for developing concepts of health and health promotion in the courses offered, but practically nothing overtly called health promotion/health education or concepts of health. There are many relevant aspects of nursing, sociology and psychology but unless students' attention is drawn to issues, they will remain to be seen by students as parts of psychology, sociology and so on.

Unit 5 does not make any explicit reference to health promotion concepts and the only potential opportunities in Unit 6 are study days of the students' choice and professional issues and interpersonal skills.

The theme of health education has objectives stated which are:

Unit 4:

* Review models of the health education within practice.

* Begin to apply the concepts of needs in relation to patients/clients.

Unit 5:

* Begin to apply appropriate health education strategies utilising available resources.

* Begin to demonstrate through care/client interaction, an appreciation and insight into the factors which prevent or interfere with health status

* Begin to evaluate the effectiveness of his/her health education practice in terms of promotion of positive health.

Unit 6:

* Actively promote positive health, working with clients and helpers to facilitate improvement in health status.

* Actively assume the role of the nurse as health educator.

How these objectives are incorporated into the nurses' repertoire seems to be left up to the discretion of the individual teacher as it is not easy to see how this is achieved from looking at the curriculum and sample timetables. There appears to be no overt mention of designing health education strategies, or concepts of positive health, or evaluation.

Mental Health and Learning Disabilities Branches

Both these curricula were sparse in terms of overt references to concepts of health and health promotion/health education.

These two Branches are effectively incorporating a tremendous amount of progressive, innovative and socially orientated health promotion but failing to recognise it and so 'label' it and claim the skills as contributing towards the nurse as a health promoter. There is a great deal in these two curricula, which is not evident in the other Branches about the nurse as an advocate, working in a partnership with clients, there is emphasis on self-growth and relationships. A strong emphasis on social, political constructions of oppression, references to gender, class and ethnicity are considered important. These are fundamental and essential principles of health promotion and it is possible that these opportunities are wasted as there is no indication that the students would perceive these concepts as ones which 'belong' to a philosophy of health. The Learning Disabilities programme has one of 12 themes called 'Promoting Health and Maximising Independence' but otherwise had a very strong emphasis on individualism and lifestyles.

The philosophy within which these curricula are immersed is very similar to the 'newer paradigms' of health and health promotion which are evident in the WHO 1984 document and in the research by Macleod Clark and colleagues (1992) - but with no acknowledgement to this body of knowledge made explicit to the students and valued the opportunity to expand and develop these skills is possibly wasted.

READING LISTS

The sample reading lists were lacking in terms of their health promotion or health education content. Health promotion or health education can also be accessed through nursing, psychology and sociology texts but it is also important to have a proportion of texts and references which are noticeably health promotion or health education. First year students do not yet have the skills to identify which aspects of the social and behavioural sciences are applicable for their health promotion knowledge base and so need texts which are clearly identified as being to do with concepts of health.

In defence of the curriculum, it can be said that the amount and quality of suitable health education/health promotion texts has dramatically increased over the past few years and reading lists need updating yearly. Tutors usually provide current reference lists for each lecture.

Nevertheless, only a small number of references pertaining to concepts of health were found.

In Unit 1, only one book out of 16 was identified - which referred to health and ageing.

In Unit 2, there were 2 out of 20 - one of which was a 1979 text and inapproriate for first year nurses.

Unit 3 had one book out of 35 - 'Patient Teaching' edited by J. Wilson-Barnett 1983;

The Child Branch reference lists contained in Unit 4, 2 out of 55, and in Unit 5, 2 out of 39.

The Adult Branch was found to have no books out of a selection of 35 that could be directly identified as health, health promotion or health education.

The Mental Health curriculum had no overtly labelled health promotion texts out of a selection of 150. There were numerous texts here however on gender and some on mental health, but none on identifying strategies for promoting Mental Health by nurses. There were many related and suitable references on the indicative reading lists but the students would not be able to 'label' them as to do with concepts of health or health promotion.

The Learning Disabilities Branch had none out of a selection of 63.

It would appear that the Branches take a very separate and isolationist approach. Each discipline appears not to require any knowledge overlap in their students. It is as though mental health nurses for example, have nothing to learn about health promotion from general nurses writing health education or health promotion texts and vice versa.

Whereas many would argue that the purpose of Common Foundation Programmes is to provide all students with general principles about promoting health and concepts of health which are transferable to any discipline, patient or situation.

CURRICULUM CONCLUSIONS

During the Common Foundation Programme, the philosophy of health and the health education commitment peaks during Unit 2 and dips substantially in Unit 3. It is only minimally evident in the Branch programmes with occasional concentrated attention.

Many aspects of a philosophy of health do appear within the curriculum, within other disciplines, but there does not appear to be an overall integrating strategy.

The 'normal' functioning theory takes place in Unit 1, where the students do 'normal' placements; child, family and work - general representations of our society. The assessment is a lifestyle project associated with a neighbourhood study. The students do not appear to have been exposed to aspects of the nurse's role in promoting and maintaining health of well people.

In Unit 2 the theoretical content is wholly immersed in a philosophy of health and health education. The clinical placements are with community nurses, all of whom, except perhaps the health visitor, will be caring for sick people. All these nurses will have trained from within a disease model perspective and most probably will have had less theoretical input on normal functioning, models of

care and a philosophy of health than the students themselves. Role modelling will be very difficult.

The students will not have had any theoretical or clinical exposure to the nurses' role in promoting and maintaining the health of well or sick people. They have experience of medical and educational models of illness prevention and lifestyle advice and negligible attention to the newer health promotion paradigms. The theory appears to be out of step with the placements.

Ideally, the theory should be primarily concerned with developing a **nursing** theory for promoting health in all types of clients and situations and the placements should be where students can observe lay and professional health care workers promoting health, in its broadest interpretation. Examples of both individual and community work in health promotion is needed.

The talk of applying the knowledge base about 'the normal healthy person' to the practical and intellectual abilities of promoting health, has been left to the student to do alone, there does not appear to be space on the curriculum for this. It is of course possible that this integration may occur due to the motivation of the individual lecturers or to the abilities of the student, but there is no explicit reference to it.

Liaison between Branches and more consultation, shared reading lists and learning would help promote general principles of collaborative work.

The Common Foundation Programme needs lecturers with specialties in Learning Disabilities and Mental Health to teach health promotion as well as nurses from a general nursing background.

One noticeable omission from the Common Foundation Programme curriculum document was reference to Women's Health issues. These concepts were addressed briefly only twice during the first 18 months, although race and social class were mentioned many times.

The language use throughout the curriculum also raised issues. There was the continual and repeated use of the term 'man' to represent the person. The importance of the **way** we use language has been the subject of academic study for a considerable time. Sapir (1970) proposed that we use words not only to communicate our thoughts, but to formulate thoughts as well.

'Language is a guide to social reality...(it) powerfully conditions all our thinking about social problems and processes'.

and in 1976 Wharf suggests:

'Language is not neutral. It is not merely a vehicle which carries ideas. It is itself a shaper of ideas, it is a programme of mental activity'.

There is considerable research to support the contention that language predisposes people to perceive women as inferior or in a negative way when used carelessly. The convention to use the word 'man' or 'mankind' to represent women as well, is purely a socio-political one. In 1972 Schneider & Hacker tested the hypothesis that 'man' is generally understood to embrace 'women' when 300 students were asked to provide illustrations for chapters in a sociology textbook. Half the group were given titles such as 'social man', 'industrial man' and political man' and the other half had corresponding titles such as 'society', 'industrial life' and 'political behaviour'. Overwhelmingly, the results indicated that when the word 'man' is used, people think of males and **not** females. Only the titles without the word man in them generated images of women and children.

Similar studies have shown the same results (Nilsen 1973, Harrison 1974, Miller & Swift 1979).

This phenomenon may be linked to the mainly male composition of the Diploma in Higher Education (DipHE) implementation and resource groups, described below.

Diploma in Higher Education (DipHE) implementation and resource groups

The committees which met to design, support and advise the curriculum were outlined in the curriculum document.

Of the 40 individuals who met on various sub-groups there were only two members who represented community care - a college based community tutor and a paediatric liaison health visitor. As the Diploma in Higher Education (DipHE) document aims to produce nurses who feel comfortable working in community and hospital this lack of consultancy with senior nurses based in the community, could be seen as an omission.

Another noticeable imbalance in the composition of the group is the predominance of males over females. The men on the committees were mainly in senior positions and the women mainly in junior positions. This may account somewhat for the lack of awareness of gender related issues and for the over use of the word 'man' to represent the person.

There were nine members whose genders could not be determined - 2 professors and 7 doctors, all from the local University. In total there were 27 men and only 14 women. The design team had 3 women and 17 men, the sub-group Branches were more balanced but all the Child Branch representatives were women and of low status and the Mental Health and Learning Disabilities were all male in more senior positions. All the Senior Tutors and Hospital Managers were male.

One sub-group which negotiates conjoint validation with the Health Authority was composed of 6 men and 1 woman. The curriculum resource groups had 9 men and only 3 women who were in grades of tutors and above.

At every level, except perhaps the clinical tutor level, men outnumbered women and were always in senior positions.

ENB 870 and Flexible Conversion Course Curricula

ENB 870 is an introduction to the understanding and application of research.

The course philosophy has an emphasis on empowering strategies necessary to initiate and sustain change.

Steinaker and Bell (1979) is the curriculum model used. Generally, this appears as an excellent, erudite document but does not have any direct reference to a philosophy of health. However, the course is currently run by a lecturer who specialises in health education and therefore the focus will have currently changed. The curriculum document was written by lecturers, who now no longer run the course.

The Flexible Conversion Course (second to first level nurse) runs for 104 weeks on a part time basis. The students have been taught theory for 28 weeks, 24 weeks of which will be formal teaching and 4 weeks open learning.

The remaining 46 weeks will consist of experiential opportunities to facilitate identified learning outcomes.

There is a common core curriculum, similar to the DipHE. Nursing and health care themes provide the framework for learning:

* phenomenological person
* teaching/learning approaches
* helping relationship skills

* management principles
* research and its implications
* nursing theories and process
* legal and ethical framework
* community studies
* health education

The health education core theme encompasses a philosophy of health fully and meets all the requirements of national and international policies. A very broad interpretation of health promotion is taken, focusing on empowerment and collaborative as well as the more usual medical and educational approaches.

The reference lists contain relevant, appropriate and up to date texts, clearly identified as belonging to the discipline.

It was not possible to determine how much overlap and interaction occurs with other core themes. It seems probable that these issues are predominantly dealt with on this core theme.

Generally a good input of health promotion/health education was seen in this curriculum: the most integrated and centred in current health promotion concerns of all the curricula examined.

THE LEARNING MILIEU

This section explores the Learning Milieu within which the curricula described above were being implemented.

The following aspects of the data were considered: our general impressions and welcomes; the physical and social environments; the semi-structured tape recorded interviews plus informal 'chats''; student questionnaires (Appendices ix and x) and discussions and classroom observations (Appendix viii). As emergent hypotheses developed, we tested these against participants opinions. A student Health Fair was in progress whilst were at Centre A and an unusual student drama group were also interviewed.

This group of students, who called themselves Choice 2000 spend some of their spare time producing drama workshops on sexual health for local school children. This had involved them in some collaborative work with the local Health Promotion Unit.

Our initial welcome to the Institute when we arrived for data collection was warm and friendly and we were allocated a desk in a shared office and a smaller room was identified for our interviews. People were friendly and helpful and there was an atmosphere of busy efficiency. On one occasion when 2 researchers got lost in the large grounds at lunchtime, an unknown member of the clinical staff came to their rescue and ferried them 'home' in her car.

It was also usual to find someone who was driving home via the town railway station at the time we were leaving and lifts to the station were usually offered.

It began to emerge that almost all the lecturers we spoke to had no part in the design of the curriculum and so our analysis concentrated on the learning milieu in which they had implemented the programmes.

Interpretations of a philosophy of health

All the lecturers and other staff we spoke to felt positive about the new emphasis, although some expressed concern about the enormity and difficulty of the task.

"It was a very big leap - it has also been a leap for service" (Lecturer).

"We were amazed that the first thing he (the new Director) said was before we could rewrite the curriculum, we had to have a philosophy. Well, first of all we had never heard of the word philosophy and secondly, did we want one?"

"Anyway by the end of the day, we had a philosophy. It didn't mean a lot to us, it was a lot of hard work... and we didn't have any argument about it and we all filed it away!" (Lecturer).

Most were extremely positive.

"I think it's brilliant" (Lecturer).

A clinical staff member expressed her 'conversion'. *"I was a bit sceptical about the new Project 2000 students but by Unit 5 or 6 it seems to work quite well".* When asked whether the changes were effective in nurse education, the response was *"two years ago I would have had to say NO, but now Project 2000 nurses are good. We need to move away from original views and images, we are changing, the appearance of Project 2000 may be different from normal - shaved hair etc, but they make excellent nurses... nursing is getting more*

personal..I'm converted..I've changed my mind". (Ward Sister)

The lecturers expressed well informed, knowledgeable views about health promotion, describing values belonging to the newer progressive paradigms as well as traditional educational and lifestyle paradigms. The socio-political aspects to health promotion were not omitted, national and international policy relating to health promotion and a philosophy of health were mentioned by some.

One lecturer commented:

"That I tend to concentrate on the idea of empowerment and guiding a client group" .

and

"Sometimes what I end up teaching seems more like counselling skills than health education - but I think that's what health education should border on, is counselling skills" .

also

"I really want them to think about what health is for themselves. And begin to look at the fact that other people will have other views on what health is - that is something I see as quite significant in nursing - we tend to get socialised into a particular way of viewing health, more of a bio-medical view and then we tend to carry that in to the health education practise that we do" .

One lecturer held a bio-medical view of health promotion and taught the topic in themes. This lecturer emphasised the importance of the mind/body equilibrium and expressed very positive views towards health promotion. The primary source of influence regarding health promotion concepts had come from the lecturer's spouse and not from nursing colleagues. The respondent's view (a tutor) had *"not really"* changed since working on the DipHE curriculum. A deficit model framework was used to describe students' abilities.

*"What is **lacking** in nurses is basic physiological knowledge" (our emphasis).*

When members of the team hold different models of care (and rightly so) with some emphasising the importance of a knowledge base and others emphasising the importance of the process and the relationships, it is vital that students are

helped to integrate these perspectives, it is a very difficult task for a student to do unaided.

Another lecturer describes the 'ideal' product from a DipHE course thus:

"A student who sees nursing as a career - particularly for the female - to have a vision for themselves and for their specialism - to be able to stand up and reflect and not give up. Not to be disillusioned too easily. When the reality doesn't meet the ideal, to have the verbal ability to articulate their needs and wherever they go to be a model of the new person in nursing, to continue to have education, for ***them*** *to want to do it (not just because of PREPP), to have flexibility, to understand there are many care settings, so their career opportunities are diverse - to look forward to being equal particularly in teams - even team leaders. Also to achieve posts that don't have nurse in the title.. I hope they will be ambitious for their profession, wherever they go" .*

A lecturer also commented that

"What is important is the relationship I have with the students and the relationship they have with patients".

This comment was in response to a discussion about the students' knowledge base.

The difficulty of developing a curriculum which was fully integrated was evident from some of the intellectual struggles that occurred.

One lecturer said

"If you're not supposed to be talking about disease, how are you going to present physiology ? On top of that he said it had to be integrated, it ***cannot*** *be fragmented... how are you going to teach psychology and sociology with the cell ? He said it* ***had*** *to be integrated".*

also

"oh yes, this is another thing, because we are supposed to be promoting empowering as part of the health concept of the individual, we are not supposed to go in there and talk ***at*** *them, but to be facilitative!!*

and

"well the first session, the Director did it..., we (the staff) enjoyed it more than the students, we could hug him, I tell you. I remember we told him you are so clever! - he was a bit taken aback... he was superb - we were pretty impressed, it was 1987 we are talking about".

Another lecturer involved in teaching health education said

"In terms of the curriculum... I would prefer health education to be brought in, in more areas, instead of just one block, I would prefer to see it linked in better because at the moment it's one block in one particular module and it gets forgotten until they have another study day and it may be a year and a half later... it should be integrated in a few more places".

The research team found all the lecturers they spoke to were positive and well informed. Many staff members have post graduate qualifications in health education/health promotion. The respondents were enthusiastic and motivated towards implementing the curriculum. Concepts that related to the newer paradigms were apparent.

Those lecturers taking Masters degrees in health related subjects were able to clearly articulate their commitment to the social, psychological and political aspects of a philosophy of health and now they had moved away from the medical, individual lifestyle approaches - a "Gung ho" approach as one lecturer commented - "*where you go get your vitamins, you are always jogging and you are determined to reduce those risk factors! That is good if you choose to do it but if you feel you are being pushed into it, then that's not necessarily healthy".*

Preparation for a philosophy of health within the curriculum.

Many teachers were recruited at the time of the change in philosophy, who had been educated within a holistic health philosophy and so had been 'prepared' elsewhere - on previous degree courses. Other teachers, on the whole felt that they had been very well supported to pursue further courses. Several have diplomas and degrees in relevant topics. Specialist teachers who were non-nurses are in post to teach the 'ologies'. The Health Promotion Unit provided all the specialist teaching until the nursing team was able to take over.

One clinical teacher commented that *"she had always picked things up about health as she went along".*

Most of the lecturing staff felt that the preparation and support had been good.

The clinical staff and public were prepared by a series of 'roadshows' which set out to sell the idea, to inform and to educate over 500 people, mainly professionals, were accessed by this approach.

The Health Promotion Unit provided numerous study days on relevant topics attended by small numbers of qualified nurses. Practice nurses have a primary care facilitator who works partly for the Trust in developing courses for community nurses, and partly for the Health Education Unit.

Responses from clinical staff varied. Predominantly attitudes were negative towards the new DipHE students, although some respondents claimed to be positive about a philosophy of health, their examples tended to indicate they were thinking from within a medical model approach about health education.

"families, no, no they are not really involved in care" and "psychological support gets forgotten in the hustle and bustle". "Health promotion - I always think of smoking" (Ward Sister).

Opportunities were identified which would enable health to be promoted on the wards; which included a teacher/practitioner on all wards, team nursing and the 'named nurse system'.

Operationalisation of health within the curriculum

When viewing the curriculum from Meyer's (1986, 1988) perspective, some of the points she identified are apparent.

The exploration of wider social and political aspects of health care are evident, especially in the Learning Disabilities and Mental Health curricula and in the session we observed and discussed, informal teaching methods are used very well.

There has been a strong commitment to integrate concepts of health with other topics, although this has only occurred in Unit 1, to some extent and in Unit 2 to a greater extent. After Unit 2 the emphasis both to a philosophy of health and its integration diminishes.

There is an emphasis on the community but only in the community as in community nursing i.e. individual nurses working in a similar way to

institutional nurses with individual patients and not in a social or political context of collaborative and innovative ways of working. The ambiguity of this term has been discussed elsewhere (see Chapter 2).

There has been some attempt to encourage the students to explore their own values and attitudes although this has been reported not to be very successful in the Common Foundation Programme.

In answer to a question about students looking at their own attitudes to their own health, one lecturer said:

"No. I've tried a couple of times to get them to look at it in pairs, look at their health and see if they can go through the health education process and the first time I did it, it wasn't particularly successful but its something I probably will try again and perhaps with more structure, so they will be able to do it'. So there's very much the assumption that providing you have the knowledge then you can go on and do it".

More self exploration may occur in the Mental Health and Learning Disabilities sessions, although this was not apparent from the curricula.

Finally and most importantly a philosophy of health and health promotion has not been seen to be threaded through the curriculum, as after Unit 2 there are few overt references to it.

In terms of the paper by Mcleod Clark, Wilson-Barnett and colleagues (1992) there was little evidence to suggest that the 'newer' paradigms were being operationalised by the students or the practitioners with the notable exception of the Learning Disabilities students.

The lecturers responsible for health and health promotion seemed committed to progressive models and the newer paradigms, however the responses we elicited from students were firmly with the traditional health promotion models.

In response to the question, what is your understanding of health promotion/health education? responses were almost uniformly about physical health and within medical or education models.

We adopted the same framework for analysing the responses to Form A, (Appendix ix) from all the case study centres (see Chapter 3). In Centre A we obtained the following findings.

October '92 students (20 students)

Of the 12 students who completed Form A, we found the following: all the students used medical model and lifestylism approaches to health education/health promotion. There was little evidence of broad approaches incorporating empowerment, collaboration, advocacy, or the use of complementary or nursing approaches, or the use of social or community networks. There was some evidence of educational approaches, however these were firmly within a medical model paradigm. Seven of the 12 students produced poor or weak answers, 3 were moderately good and 2 were very good.

For example

"to extend people's understanding of their own body's needs and requirements. To help them maintain a healthy lifestyle. To promote people's awareness of the facilities they may require".

and

"providing clients/general public with information (on healthy living) and knowledge so that they can make an informed decision about their lifestyle.
eg. stopping smoking
safe sunbathing
low fat diets ".

As discussed in Chapter 3, Form B (Appendix x) was a complex measure and would have been better for senior students. Consequently, none of the students saw the irony of the piece or tumbled to Q4. Perhaps the reference to high technology nursing struck a chord as they all took this opportunity to complain about their lack of clinical nursing experience on the wards. Eight students completed this form, in terms of the health promotion content, four produced weak, negative answers. Three students wrote only 11, 15 and 20 words respectively in over an hour. There was no evidence that the students were integrating concepts of health promotion into their ideas about nursing care. The other four students produced only moderately good answers.

When asked whether their views about health promotion/health education had changed at all since they began their education at Centre A, 10 out of 12 students said 'no', implying that the medical, preventive, individual approaches were formed from school or elsewhere and had not been modified since arrival. (This was in marked contrast to students in two other centres who said yes.) The response to this question seemed to be affected by age.

The general picture which was presented by the vast majority of students was that 'health' or health promotion was centred around giving out leaflets and advice to improve individual's unhealthy behaviours, and they generally found it very difficult to articulate how the theory they have learned could be applied in the clinical areas.

The placements were generally not found to have been very helpful to the students in enhancing their understandings and they all felt a strong need to have access and experience of hospital wards much sooner. Their experience of a philosophy of health and health promotion was not seen to be helpful in preparing them for the 'real' work of nursing.

Learning Disabilities Students

Two representatives from the Learning Disabilities Branch were striking exceptions. These two students were able to express positive and enthusiastic comments about a philosophy of health.

They were able to use concepts from the newer paradigms - they were concerned with promoting mental health, wellness and political awareness.

These students felt that the health promotion and concepts of health presented in the Common Foundation Programme were not really applicable or helpful to their discipline and so they needed to think about what sort of approaches were appropriate for their clients.

"In the Common Foundation Programme, in the first 18 months of the course, I would have a different understanding of health promotion then and it was focused on keeping people healthy, looking at people's diets, the way they live, encouraging them to take exercise etc but having moved over to Learning Disabilities, there are so many more problems there. A lot of them are very unhappy because they are oppressed basically". (Student A)

In answer to a question about applying the theory they gained in the Common Foundation Programme to their clients one student replied:

"Well, in a way, but they have very little else. If somebody has been smoking because they have very few rights and any other enjoyment, it's very difficult to say to that person, "hang on, this isn't healthy for you" because you have got nothing to replace it with that would be better. And a lot of the time, food is their only pleasure, especially if you've got someone with sensory and hearing disabilities - actually tasting food and things like that is really important to them

and so how do you.... obviously you have to balance. There's a lady at the moment I'm looking after who has Downs Syndrome and the people who were looking after her had gone through lots of arguments because she had cataracts and she went blind overnight, and this lady's behaviour changed, she was awful, she was really frightened, she was smearing faeces, she was stripping and they had a terrible time to get this operation on the NHS. She's actually had it done now and it has changed her life completely but she is putting on weight and is enjoying her food and we are saying 'what should we be doing here ? - it's very difficult. Do you know what I mean?

I think you've got to strike that balance. A lot of people, all they have is their cigarette which they enjoy and look forward to and I say, yes, try to stop if you can replace it with something meaningful for them".

Also

"I think that the philosophies that we follow of social valorization and bringing rights and dignities into people's lives is a good strategy for promoting health education because you are attempting to bring normality and the same opportunities to people and in that way they are going to be more developed and happier and with it a healthier person, so I think that philosophy in Learning Disabilities actually you do follow that road.

In a sense, with the emphasis on health promotion, because we are actually trying to promote health in a sense like the resolution from the WHO, because that's all in with this isn't it. (Student A)

When asked what sorts of thing make it easier or more difficult to implement their health promotion strategies, Student B responded:

"If people have the attitudes, what I call the old institutionalised attitudes, it's very difficult for you to come along and say 'right, I think this should be done' because they have spent so many years here and they know the clients better than you do so 'that won't work, we've tried that before' so to try and change is difficult. The only way you can do it is by example, you can keep telling people, but by doing it yourself and people seeing you do it and that working.."

This student demonstrates a true understanding of the concept of choice here and alternative therapies were mentioned for the first time:

"Yes, as well as the hydrotherapy and the reflexology which the physiotherapists do which we can refer our clients to. Reflexology seems to be quite beneficial

to some people. At the moment, that seems to be in the domain of the physiotherapist in this area, I think we could think about that later on, because to have to have that intimate contact with your client, because very often our client group don't have anybody and just to be touched is quite nice for them". (Student A)

The idea of different and separate cultures of the Branches emerged:

"I think its the different cultures in nursing because I think the general nurses, you do have to suffer, don't you, you've really got to work hard and you really don't have to have any feelings and I think that's still there somehow. And larger groups as well, whereas we have all got to know one another and trust one another. They haven't had, I don't know if you are going to speak to any general students, they've not had the support that we've had. I think we have been extremely fortunate right from the word go". (Student A)

Similar views were mirrored by tutors as well.

These were the only students in our sample who mentioned the concept of advocacy - and only after some prompting, despite it being a feature of the WHO (1984) policy document. (Appendix i)

Flexible Conversion Course

The representatives from the Flexible Conversion Course (second to first level nurse) indicated that the course was already affecting their clinical practice. They had developed an understanding about choice, empowerment and realistic factors that constrained innovations. They were aware about political and social influences.

The students themselves felt very disempowered - despite their tutors attempts to support them. Many were doing the course in their own time and suffered considerable stress about the funding of the course.

The attitudes and approach to a philosophy of health was positive, which indicates that enlightened tutors **can** change hearts and minds. However, their views about the DipHE students were negative, all the 'old' cliches appeared, which seems incongruent with the views expressed about the changes in philosophy. They felt the DipHE students were arrogant, didn't have any practical skills, although they did feel more 'easy' with students since starting their own course.

ENB 870 students

We also explored the issues about how a philosophy of health was perceived in the clinical areas, by discussion with the ENB 870 research group.

This was our most difficult and unco-operative interaction of the whole research project!

There were seven students, two men and five women, two of whom did not speak or contribute at all.

The students were evidently most reluctant to participate and we were just on the point of leaving when someone said *"turn the tape on and lets get on with it".*

When asked for examples of the opportunities which they found in their own clinical workplace for promoting health, the examples which were volunteered, particularly by the two most vocal students were exclusively within the medical model: immunisation; breastfeeding; family planning, post-natal little talks; discharge checks. There was no evidence of planning with patients or negotiating care and the patients were referred to as 'ladies'.

This lack of general awareness and lack of respect towards women, was also seen in the constant deferral to the male chairperson of the group. Other examples of a purely medical model approach were evidenced. When discussing barriers to promoting health in relation to smoking, one student commented *"you just keep on telling them". "The recidivists are the problem, you just want to throw up your hands".*

and also

"What do you do about diabetics who ***abuse*** *their diets"* indicating on the part of the nurse, a lack of awareness about choice and power, and a view that the patients themselves are the barrier to health promotion.

The responses to a philosophy of health as evidenced by the DipHE students drew the most extreme and negative comments. The general tone from all those who spoke, except one, was hostile, mocking and dismissive. A torrent of abuse towards the DipHE students emerged, along with derisive laughs and gestures. They did not like the DipHE students' attitudes, their lack of professionalism, they didn't like them being supernumerary and they didn't like the way they behaved and acted. The 870 nurses claimed that the DipHE students lacked

communication skills and that they just sat at the desk at did not want to talk to patients. One respondent commented *"You can get one rotten apple that can affect all the others"*. They complained that the students wanted to leave on time (clearly not recognising that assertiveness in students can promote health and staying late on duty can breed resentments). Generally, they felt they were 'not in the mould' and it was the fault of the school as they told them they were 'special'. The only ones they liked were the ones who had been auxiliaries before and who presumably came with 'orthodox and traditional' views about nursing.

One nurse resented the fact that they didn't even know how to make a bed. She said *"I certainly don't have the time to teach them, they should know before they come"*.

The only dissenting voice amongst this group was a female nurse who worked in mental health. Her views were positive, knowledgeable and encouraging about DipHE students. She was able to give a variety of examples of how to promote mental health and had positive experiences of working with DipHE students. She was able to identify what the new students needed to know about the ward and help them. She did not perceive the students as being there to ease her workload.

This positive view from the mental health field was echoed later in the week by a lecturer who claimed that *"the mental health nurses can't wait for the Project 2000 students to finish, so they can recruit them"*.

The lecturer for this group of students expressed her surprise at their reluctance and at the negative attitudes expressed.

The profession has an immense task ahead to prepare trained clinical staff of many years standing, for radical changes in philosophy so they can adequately support students.

Class Observation

In terms of how the curriculum is taught, we gained the impression from talking to teachers that informal approaches were used. We observed one class where the lecturer created a very good rapport with the students (Mental Health Branch). All the students participated in the session of a potentially controversial topic. The lecturer demonstrated good facilitation skills and involved the students in a variety of positive activities. The perspective taken was from an individual psychological approach and the nurses' role in health

promotion could have been made more explicit.

The College as a health promoting environment.

Overall, the majority of respondents considered that the college was a healthy place to work. The physical surroundings and facilities were excellent. The provision of a counselling and occupational health service for students was also appreciated. Although one student did comment that the occupational health nurse talked **at** them in a very 'top-down' advice giving, patronising way.

Lecturers were aware of empowering students and were making efforts to achieve this. The assessment system had been modified so that it was less stressful for students.

The staff generally felt supported amongst the constant background of change that they were subjected to.

Students reported high levels of stress and some had developed some degree of insight and coping strategies. Lecturers also felt that for those staff members who found the new philosophies and changes difficult, new roles had been identified for them in the new structure. Lecturers too reported high levels of stress.

Finally, two interesting student initiatives were included in our analysis: the student group Choice 2000 and a student Health Fair.

Choice 2000 is a student run drama group facilitated by a lecturer. The initials stand for Choose Health Over Illness, Choose Education. Workshop type dramas are produced and shown to local school children, with a sexual health promotion message. This activity takes place in the students' spare time and has involved collaborative work with the local Health Promotion Unit. Approximately 17 students were involved at the time of the research. The library was promoting a feature on the group during our visit, of photographs and information. This was a unique initiative and we did not observe anything quite so creative and innovative in the other centres.

The Health Fair was in progress when we arrived at the Institute of Health. Students were running a variety of stalls on different 'health' themes, including alcohol prevention with an interactive quiz, heart disease prevention, there were alternative therapies on offer and a wide range of other stalls. The idea for the fair was initiated and supported by a lecturer. We were there at the beginning of the day when the attendance was poor. A great deal of work had gone in to

preparing the fair from which more people could have benefited.

CONCLUSIONS

The academic team who designed the Diploma in Higher Education curriculum and the ENB 870 curriculum are not responsible for implementing them. New lecturers are now interpreting the curriculum and teaching it according to their own interests and abilities. It is possible the weakness in the written curricula are being corrected and likewise the strengths may not be operationalised. The reading lists, for example, need to be more geared to a philosophy of health. This point was illustrated by the Flexible Conversion Course reading list.

We also found a contradiction in the written document, which made almost no reference to gender, but there were many references to race and class, during interviews. One male lecturer commented there was **too** much emphasis on gender and Women's Health, and not enough emphasis on race, which he referred to as a local 'backlash'. This bias was not apparent, however in any student response.

Although there was considerable emphasis in the Common Foundation Programme, particularly in Unit 2 on concepts of health, it was not evident that this trend followed through to the Branches and so it appeared to the team that a philosophy of health had not been successfully integrated throughout the whole curriculum. The ENB 870 research course was not immersed in a philosophy of health in the written document but was taught by a lecturer who was committed to health and health promotion.

The Flexible Conversion Course was both written and taught by those committed to a wide and progressive philosophy of health and health promotion but the extent that these concepts were integrated into all the taught themes, was not clear.

On the whole, the placements in the Common Foundation Programme were seen by the students as not very useful and they would have preferred to be observing 'real' nursing on the wards.

As in the other centres, the research team suggest students need to observe a wide range of health professionals, working with varied models of health promotion. The students need experience of implementing health promotion with both well and sick clients and a unique and specific model of health promotion applied to nursing developed.

Currently, during Unit 1, the students observe only 'normal' behaviour and do not begin to develop any concepts of a nursing role in health promotion. In Unit 2, it seems that they are exposed clinically to preventive, medical and educational models within an individualistic approach.

The lecturers are the only group in harmony with international WHO policy as the clinical nurses hold orthodox, traditional views.

The Branch programmes appear separate and could benefit from collaboration.

If those lecturers with a MSc in Health Education could contribute to writing the Learning Disabilities and Mental Health curricula and some of the Mental Health and Learning Disabilities lecturers contribute to teaching, advocacy, political and social awareness, stress and relaxation, in the Common Foundation Programme, for example then many of the issues outlined above could be resolved.

A philosophy of health and the nurses' role as a health promoter needs to be revisited regularly through the 3 year programme.

The DipHE philosophy was originally planned to produce nurses who were able to work both in the hospital and the community but most DipHE nurses are getting jobs in hospital.

In the Common Foundation Programme, there needs to be less emphasis on physical health and more on mental health.

The placements in Units 1 and 2 are not being used by the students to their best advantage. If more time in preparation and in feedback occurred and the students were more aware of the potential for learning, their placements would be more beneficial. Ideally, the students need to work with people who are knowledgeable and clear about the models of health promotion they are using which go beyond the preventive medical approaches.

The role models they meet on the wards are likely to have only a preventive medical model view of health education and so the students need to be exposed to the newer paradigms to ensure a balance.

An issue which has arisen in all the centres is to do with distinguishing a nursing approach to health promotion as distinct from health promotion which may be studied by a Health Studies degree student.

Students saw health education and health promotion as entirely separate from the

'real' practical work of nursing. Students were not able to articulate how to promote the health of sick people, only able to discuss how to prevent illness, by advising on how to change unhealthy behaviour.

CHAPTER 6

CENTRE B - COLLEGE OF HEALTH, WEST CAMPUS

OVERVIEW AND ORGANISATION OF FINDINGS

Formerly - Three separate Colleges of Nursing and Midwifery.

The college has been integrated on its present site since 1990. the site is an old psychiatric hospital that is now only partially in use (80 in-patient beds remain). It is a listed building and the conversion from hospital to college has been done sensitively and the decoration is light, bright and tasteful. The college also hosts the schools of Radiography and Physiotherapy. There is a lecture theatre that seats a whole cohort of Diploma in Higher Education (DipHE) students (up to 150) and many purpose built seminar rooms for 20-30 students each.

Two to three tutors share offices whilst senior staff have their own offices. There are also designated interview rooms for personal tutorials and counselling.

The grounds are large and attractively landscaped but no on-site sporting facilities are available. The college has a canteen with subsidised meals although the menu does not offer many healthy food options. There is a student common room and teachers have a pleasantly furnished coffee lounge.

The current library is an amalgamation of stock from the original colleges of Nursing, Radiography and Physiotherapy with heavy investment since the introduction of the DipHE. Students are also able to use the library at the 'new ' University which has particularly good 'ology' sections (i.e. sociology, biology, psychology). There are librarians responsible for certain curriculum themes eg sociology, nursing etc. Health is not treated as a separate theme. The health education/health promotion section of the library has trebled since the introduction of the DipHE and the librarians have noticed a change in the type of books requested which was defined as being more 'person-centred'. As a result of the current changes in the structure of health care provision, Trust employees are no longer able to use the library free of charge (except for borrowing up to 4 books) unless they are students on a course at the college. All inter-library loans and video loans have to be paid for. In response some, but not all, of the associated Trusts have set up their own libraries.

There is a specific department and manager responsible for the provision of

learning resources which covers the library, reprographics and information technology. There are 17 networked personal computers for students to use and a variety of Computer Assisted Learning packages. As yet there are not any that look at health and health promotion specifically. Apparently there are few suitable packages on the market and the Information Technology tutors are actively involved in creating suitable programmes in-house. The reprographics department does Desk Top Publishing for staff and students have access to the facilities. Students can and do make videos and leaflets as part of their project work and some of these are health promotion orientated. The library is spacious, quiet and has ample study spaces. There are computer literature searching facilities and CD ROM is available.

At present, the library is situated in another part of the hospital and is thus a ten minute walk from the offices and classrooms. However, when Phase 2 of the conversion takes place, it will be rehoused within the main college. Students are also able to use the Health Promotion Unit library based at a neighbouring hospital which has many specialist journals, books and teaching packs. Phase 2 will also involve converting more of the disused wards into study bedroom accommodation for students.

Intake

The intake varies yearly dependent on the Regional Health Authority's projected nurse-power requirements. There are two intakes a year. The first cohort, September 1990 had 64 students distributed over 4 Branches. By September 1991, the intake had increased to 134, the largest intake was 142 in March 1992 and the most recent intake was 132 in February 1993. The Principal indicated that future trends would be downwards which has implications for the number of staff that will be required. It is likely that student numbers will be reduced by up to 50% next year. The Adult Branch is the largest, comprising 465 of the total, Learning Disabilities 48, Mental Health 77 and Child Branch 65.

Student characteristics

The students are mainly female. 88% (n=675) but 35% (n=77) of the Mental Health Branch students are male whereas only 8% (n=65) of the Child Branch are male. There are 146 Flexible Conversion Course students (second to first level nurse) spread out over 7 intakes, 8% are male and 16 mature entrant part-time course students who are all female. In addition there are 3 students still completing traditional courses. There are approximately 100 post-registration students yearly.

On figures gathered from the personnel department, 53% of the students are over 21 (n=691). However, the figures are not broken down to show age gradations over this cut off point. Statistics show that in the pre-registration intakes 4.7% of students are from ethnic minority groups compared with 6% of the local City population (Local Authority Statistics, 1991). These statistics confirm reports that strenuous efforts have been made to increase recruitment from local minority ethnic groups.

Teacher profile

There are 98.04 whole time equivalent (wte) members of teaching staff located at the West Campus. There are also 3.5 wte shared staff posts with the local 'new' University (in psychology, sociology and biology). Observational evidence suggests that although the teachers are mainly female there is a significant proportion who are male (about 40% and this proportion increases in the senior management tier) and only about 3% are from a minority ethnic group. Teachers' ages range from late 20s to 50s but the largest proportion is in the mid 30s to 40s.

The majority of staff have either a Bachelors or Masters degree and three staff are registered for PhDs. All staff will be graduates by 1995. Of the pre-registration tutors, three are undertaking a diploma course in health promotion, two are doing Bachelors degrees in health promotion and one is doing an MSc in Mental Health studies. Social Policy, Gender Studies and Nursing are also popular degrees. Originally staff could choose to do any degree that they wanted. However, choice is now negotiated as a compromise between individual requirements and organisational needs.

Both money and time has been invested in funding and supporting teachers doing degree studies. Consequently there has been less money available for sending people on conferences and study days. However, the principal felt that this investment had *"done the power of good to the college"* particularly in raising teachers' self esteem and confidence with the new curriculum. A senior educationalist has also been recently appointed for research and development whose main remit is to encourage and support college staff in research activities.

The principal meets monthly with the Chief Nurse of the 5 associated Trusts, a representative for the 'new ' University and the Regional Nurse responsible for contracts in order to keep abreast of current issues and developments.

All courses are currently being costed by a financial consultant to ensure competitiveness. Income generating activities are also a priority and the college

recently hosted an extremely successful sociology conference as an example of this.

The selection process for our sample and data collection

Decisions for the final selection of our sample and associated data collecting activities were taken by local staff members (a community tutor and the Senior Education Manager for research) who had been delegated this task by the principal. Their organisation, collaboration and help were invaluable.

We recognise that our sample in Centre B, as in other centres, represents the host institutions' understanding of the project and the willingness and availability of particular teachers, students and clinical staff to participate during the data collection period.

Our sample included the following: course providers (teaching and administrative staff), course consumers (students on the DipHE - all Branches and the Flexible Conversion Course, second to first level nurse) local health promotion staff and practitioners from both institutional and non-institutional settings. From the sample, we sought to investigate how they perceived the process and outcomes of implementing nurse preparation programmes based on a philosophy of health.

Course providers

The college principal during both preliminary visit and afternoon follow up visit.

Curriculum Manager
1 Learning Disability tutor
2 Community tutors
2 Child Branch tutors
1 Mental Health tutor
Senior Education Manager Adult Branch
Placements manager
1 sociology teacher
1 biology teacher
1 Information Technology tutor
1 Flexible Conversion Course (second to first level nurse) tutor

Course consumers

1 group Common Foundation Programme Term 1 students (n=16)

1 group Common Foundation Programme Term 4 students (n=11)
1 group Common Foundation Programme Term 3 students (n=13)
(Questionnaires and discussion)

Other staff
1 Health Promotion Officer
1 librarian

Practitioners
Health visitors (4), district nurses (7) and 1 community clinical nurse specialist in group discussion at a local Health Centre.

2 enrolled nurses and 1 staff nurse on a medical ward (individual interviews)

Classroom Observations
Psychology seminar Common Foundation Programme Term 1
Adult Branch Term 8 Health of the Nation seminar

Observation of ward handover:
Early to late shift on a medical ward

'Back of the shop activities'
Car journeys, walking the long corridors with staff.

THE INSTRUCTIONAL SYSTEM

1. Documentary Analysis

Course outlines and curriculum documents for the DipHE and the Flexible Conversion Course (level two to level one) were examined to elicit the stated intentions, aims and proposed educational practices.

Assessment strategies for both theory and practice outcomes were also examined. Relevant UKCC documents were reviewed.

2. Semi-structured interviews

(a) with course providers
(b) with course consumers
(c) with practitioners
(d) with health promotion staff

3. Focused discussions groups

4. Questionnaires

The interviews, discussion groups and questionnaires enabled us to check participants' perceptions of the process and outcomes of implementing nurse education based on a philosophy of health and to test emergent hypotheses against their opinions. (See Appendices v - x)

Two curricula were examined: the Diploma in Higher Education (DipHE) curriculum and the Enrolled Nurse (level two to level one) Conversion Course.

The DipHE curriculum was designed by a huge team of staff headed by the then Curriculum Manager (now principal of a neighbouring College of Nursing and Midwifery). The team had representatives from all of the Health Authorities, practitioners representing each Branch, representatives from the former local Polytechnic's Department of Nursing (including their principal who is now a nursing professor at an 'old' university) and the Department of Education and a headmistress from general education. The curriculum took 3 years to develop and was validated in October 1989. Many changes have been made during the operationalisation of the curriculum as a result of student evaluation and the experience of running the course. For example, the nursing theme has been strengthened and the pure 'ology' teaching reduced; the placements have been reduced in number but lengthened. The curriculum is due for re-validation in December 1994 and preparations are already underway for this. The new curriculum will be in modular form and nursing will be a strong theme throughout.

What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents?

The educational philosophy in the DipHE submission document refers to 'pedagogic' aims, although Knowles' (1970) concept of andragogy might be thought to be more relevant to adult learning and such concepts as empowerment and self-direction. Nevertheless, the importance of students becoming critical, self directed learners is stressed.

The knowledge base explicitly referred to includes behavioural, biological, social sciences and nursing theory. Diplomates are expected to be able to deliver care

in a flexible and effective way to meet current and future health needs both in community and hospital settings.

Nursing is seen as the integration and application of subjects such as biology, psychology, sociology, social policy and ethics to health and health care. There is a definite sense of nursing occurring at community as well as individual level. The goal of nursing is seen as improving health status.

Teaching/learning methods include: lecture; seminar; group tutorial; individual tutorials; projects; presentations; practical application; self directed study; computers peer group teaching; role play and workshops.

The main aim of the Conversion Course as stated in the curriculum document is to change the professional focus of course members from working under the direction of others to one where they are able to function effectively within the framework of the UKCC competencies for first level nurses.

The students are encouraged to take responsibility for self-directed learning, self assessment, peer group interaction and the development of research awareness. The course is extremely flexible and the length and content is determined by the students' personal needs and experience and is based on contract learning. Students remain in their current service posts and negotiate experiences which will assist them to achieve the course outcomes. All students have a named person to act as a role model and a mentor during the course.

One of the 5 study modules is Health Studies. In this module students explore concepts of health and the holistic nature of health is emphasised. Factors that contribute to ill-health are discussed and the environment, social class, race and culture are identified as key issues. The students are introduced to health education and consider the provision of health services and inequalities in health.

To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application ?

Health is acknowledged as being ambiguous and difficult to define although for the purposes of the DipHE curriculum it is defined as overall well-being rather than just absence of disease and the WHO model is referred to. A holistic view is adopted. It is also explicitly stated that the students' own well-being should also be promoted.

During Common Foundation Programme Term 1, 52 hours are expressly devoted to health studies and the whole term is called "Health in Society". Term 2

focuses on the child in society and students are introduced first to the healthy child and end the term by looking at the child in hospital. 48 hours are devoted to the Health Studies in this term. By Term 3 Health Studies and Nursing Studies appear as a combined theme with the focus being the adult and older people in society. The final term of the Common Foundation Programme (Term 4) explores nursing practice and process and although health is not mentioned explicitly, concepts such as power, access and opportunity which are central to health promotion, are dealt with. An understanding of the concept of health is seen as fundamental to nursing practice.

The Branches start in Term 5 and teaching then becomes primarily seminar based. In Term 5 Mental Health and Learning Disabilities students receive 18 hours of Public Policy whereas the Adult Branch and Child Branch only receive 6. However Adult Branch and Child Branch students have 48 hours of Nursing Studies as opposed to only 18 in Mental Health and Learning Disabilities. All groups spend 9 hours on the 'common core' subjects of communication and research. Health and Illness is only explicitly mentioned for Learning Disabilities students who get 18 hours worth.

This change in emphasis continues throughout the Branch. In Term 6 Adult Branch, Child Branch and Mental Health Branch only have 6 hours on Public Policy yet Learning Disabilities students have 24. Nursing Studies contributes 54 hours for Adult Branch and Child Branch but only 18 for Mental Health Branch who are instead timetabled for 18 hours of Health and Illness. Term 7 again has many more hours of Nursing Studies for Adult Branch and Child Branch students. Ethics, Law and Public Policy remain instead the key subjects for the Learning Disability Branch.

Common Foundation Programme placements aim to demonstrate the range of health care provision in both hospital and non-institutional settings. Health promotion is the key focus in Common Foundation Programme but this changes to 'care' in the Branches.

How was the course assessed and outcomes described?

The scheme of assessment is based on two main principles:-

(i) the continuous assessment of theoretical knowledge and practical skills

(ii) progressive assessment of knowledge and skills and the development of students as research based critical thinkers.

Formative and summative assessments are included. Formative assessments are designed to enable students, with teacher support, to maximise their full potential and summative assessments are designed to test the essential criteria and competences required for registration and award of the Diploma in Higher Education.

Assessment of theory

The first assignment is a Health Project that students present to their tutorial group. Students are asked to gain an understanding of how people live and work in communities and to discuss how life experiences affect individual and community health status. Poverty, housing and the environment are stressed. In the Health Studies strand students are expected to be able to discuss different models of health and their implication for nursing practice. Inequalities on health and international comparisons are also a key feature. Students also investigate models of health education and health promotion and consider ways of planning and evaluating health education initiatives. Core reading contains - Aggleton (1990), Ewles and Simnett (1985) and Townsend et al (1992)

All the assignments in the Common Foundation Programme are designed to reflect the knowledge base of the Common Foundation Programme which includes such disciplines as biology, psychology, sociology, health studies, public policy and ethics. 'Normality' or health is emphasised throughout.

In the Branches the focus of the theoretical assessment moves to nursing and students are asked to use nursing models, research, problem solving and communication in discussing the care of clients and supervision of other staff.

The marking schedule is loosely based around Bloom's taxonomy and does not ask the marker to explicitly look for a health focus.

Assessment of practice

Students progress through observer, to participant observer and finally to participant in care. 50% of the course is practice based and mentorship in the clinical areas is seen as important in helping students make the transition. Training for mentors was set up prior to the introduction of the DipHE.

The UKCC Project Paper 9 (1987) recommendation that 'upon registration the new nurses will be able to practice in both non-institutional and institutional settings' is explicitly referred to as the criterion for the selection of placements.

To this end health is a foundation concept in all non-institutional and institutional placements. Students are expected to participate in non-institutional care in the Branches.

All practical placements have clearly stated aims and objectives. A socio-political model of health is evident. For example, students in Term 3, are asked to explore "relevant public policies and their implications for the maintenance of health".

In the Common Foundation Programme communication, interpersonal skills, team work, assessment, planning, implementing and evaluation are assessed on placements. Students are graded on 5 levels ranging from 0 - knows nothing about this to 4 - the student could teach this skill and related knowledge to another. Self assessment by the student forms the basis of the assessment process. In order to pass in the Common Foundation Programme the student must satisfy the criteria associated with the placement in at least 3 out of 4 placements. In the Branch, all criteria must be satisfied. The practice assessment criteria for Terms 6, 7 and 8 do not include health promotion or health education at all.

On what basis was the 'success' or 'outcomes' of the curricula judged?

The wastage rate has increased from approximately 4% to 9-10%. This was felt to be due to a combination of factors including the fact that the course was different to the students' expectations and the higher academic level expected. The principal suggested that the entry gate might have to be reviewed .

Not all diplomates have been able to secure jobs on qualifying. However, this was felt to be due to the economic situation, the effects of the 1990 health care reforms and cut backs in the local Trusts rather than concerns about the diplomates' ability to practice.

How did the curricula compare with the UKCC guide-lines?

The UKCC guide-lines (1986) stressed that the Common Foundation Programme must be 'embedded in health not in illness' (p.46) - that students must learn about normal living and develop an appreciation that nursing care is not always and only about practical activities. Placements were to be planned systematically so that theory could be applied critically in different practice settings. They were also broader than traditional community placements including for example, work places.

Shared learning with other health care professionals was to be encouraged and the 1986 report recommended that midwifery should be a fifth Branch but this recommendation was later dropped (Centre C appears to be the only centre where there is any formal shared learning with midwives. Midwives in Centre B are presently taught on another site although they will be moving to the West Campus soon.)

Each registered practitioner should be able to practise in a variety of settings and have awareness of a broader range of health and healing experiences than can be found in hospitals.

The 1986 report also suggested that further preparation is necessary to enable a nurse with second level training to practise as a first level nurse.

All the above appear to have been acknowledged and planned for in Centre B's curricula, although external constraints particularly on non-institutional placements are apparent as discussed in more detail later.

THE LEARNING MILIEU

Interviews, questionnaires, discussions and observations were used to generate findings on the learning milieu . The sample numbers on which the data are derived are given in the section on selection process above. The validity and reliability of the data are discussed in Chapter 3.

Participants' perceptions of the process and outcomes of implementing a programme based on a philosophy of health have been identified. Identification of factors for and against the successful implementation of a philosophy of health are highlighted.

Interpretations of a philosophy of health

In seeking to answer the question:"What is a philosophy of health?" we had already defined the parameters in our research proposal, using the WHO's discussion document (Appendix i) on the concept and principles of health promotion as our yardstick. A shortened version of the proposal was given to our local contacts in each centre who in turn made it available to their colleagues.

During discussions and interviews at Centre B the following information emerged concerning the teachers' perception of a philosophy of health.

All recognised there had been a shift in nurse education which had pre-dated the introduction of Project 2000. For example, the mature entrants' course was used as a pilot for the DipHE and the 1982 Mental Health curriculum was grounded in health . A move to a philosophy of health seemed not only to be about acquiring knowledge but also to involve a change in attitudes and behaviour.

Health was defined broadly by the teachers we interviewed who emphasised such aspects as stress, relaxation, socio-political approaches and emotional dimensions .

Common Foundation Programme

The students' model of health from discussions and questionnaires appeared to be mainly a socio-political or new paradigm one, which included a focus on empowerment, community action, environment and social action. Students highlighted racism and sexism as affecting health and recognised the importance of the environment and socio-economic factors on health status. They suggested that legitimate health promotion activities for nurses could involve lobbying for improving safety in play areas and reducing environmental pollution. Most respondents identified health promotion as an essential part of nursing "health promotion and caring for sick people go hand in hand".

This view appeared to change by the end of the Common Foundation Programme. One senior education manager, while undertaking research for her MSc, found by the end of the Common Foundation Programme, students were focusing more on the sick role than health and health promotion. She had expected the opposite to happen. The respondents to our questionnaires also showed a changed perception. Their model of health was more on education and lifestyle with the focus on screening, prevention and smoking cessation, featuring frequently. However, some students mentioned political and social factors, as illustrated by the following comment by a student who was: *"aware of (the) effects of class, geography and culture...nursing is a great enforcer of health promotion but politics seems hell bent on destroying this".*

At this stage all students emphasised the advice giving role of the nurse *"the nurse, health visitor, midwife should be full of information to give".* All students had recently spent time with practice nurses which may have influenced their response. Health promotion was seen by most students as being part of nursing but that lack of time and resources could prevent it happening. A number of them had seen no opportunities to promote health in their last placement.

When teachers were asked directly whether looking at health first is the right

approach the answers were almost uniformly positive. However, when the discussion continued in a more general way, more concerns were expressed such as: *"(the) expectation of the general public is that nurses should nurse sick people".*

Some teachers felt they had to change their own thinking as the following comment infers: *"(I) had to make my own personal changes to become health orientated - but I feel I have done it successfully".* The shift was too radical at first for some: *"we were almost paranoid about mentioning the word illness in the Common Foundation Programme".* Other teachers made comments such as *"... (we were in danger of) throwing out the baby with the bath water"* and *"at one point it was blasphemous to mention disease processes".* However, all the teachers we spoke to concluded that the health input was now more successful and balanced than when the programme had started.

Some had found this transition challenging. For example it was: *"a big swing away from talking about disease processes - it was difficult"; "some teachers, myself included, prefer and feel more comfortable with traditional hospital roles" ; "there is still a sense that when dealing with biology or a (technical) skill, this is what real nursing is about"* . Some teachers left during the transition and it was suggested that a few who were coming up to retirement *"can't cope".*

Because Health and Nursing Studies were different themes in the curriculum there was a sense that the ideas got separated in people's minds. There was also a fear that the focus on health was actually making nurses vulnerable as a professional group . For example, some teachers were asking how to distinguish between health and social care, given that the concept of health was so nebulous? .

Preparation for philosophy of health within the curriculum - tutors.

A staff development programme which assisted teachers to obtain degrees, pre-dated the introduction of the DipHE and as mentioned previously, was seen as being a *"power of good to the college"* . The ENB's management of change package was used to facilitate the change process. Some teachers had completed and were doing qualifications in health promotion but it was only recently there had been a real attempt to link organisational needs to teachers' own study preferences. Health promotion was not given a priority as a qualification.

There were 'time out' days for teachers to discuss and prepare for the changes.

These were reported to have helped the relatively un-problematic amalgamation as the teachers had all met each other on study days. The workshops on such days tended to have specific rather than general functions as reflected in this comment: *"it would have been good to explore the theoretical underpinning but we were always meeting deadlines".* One teacher described herself as "self taught" . The biggest worry expressed by the teachers' rather than the shift to health was the change in the teachers' role in the clinical area, the change in academic levels and the change itself: *"the 1992 curriculum was skills/experiential based so there was a big change in the academic level .... (I was) scared of only being one step ahead of the students"* . Some teachers also had to change their methods of teaching from 'talk and chalk' to more experiential discussion based methods and this was seen as both *"frightening and pleasing"* . There was a great fear expressed by teachers from Learning Disability and Mental Health Branches of *"genericism by stealth"* and the numerical power of the general tutors .

The former 'community team' was broadened to include teachers with a particular interest in health to become the health theme team. The teachers with community backgrounds appeared to have a high profile in the college and influence on the DipHE curriculum as evidenced by remarks such as: *"community and health seemed to go together" and (there was) "great work done by the health team to make us all aware of the health issues".* Their manager acted as an effective two way communication channel for her team during the writing of the submission document: *"for a long time we have had a Senior Tutor for Community and Health because of the complexity of it all and she was our immediate resource".* Members of the health team reported the other teachers saw them as *"pains"* because they were always talking about health promotion. One of the teachers with a community background said that the DipHE made a power base for the community teachers particularly as the community team tended to be more articulate and forceful than general nursing teachers and were more used to working autonomously. A Health Promotion Officer suggested that Health Promotion Officers could have been used successfully in teaching the teachers but instead they were asked to repeat the same sessions for different student groups.

There were problems during the initial writing of the curriculum as the goal posts kept changing with regard to content and academic levels. Also traditional courses were still recruiting students right up to the start of the DipHE and the last cohorts had only finished recently .

The college as a health promoting environment

The physical working environment was perceived as "delightful" and to be reasonably healthy for the teachers. The example of flexible working hours was commented on: *"nobody expects you to clock in and clock out," although* many teachers appeared to work in the evenings and at weekends. There were staff support groups during the early part of the change period but nobody expressed the need for them to continue despite declining student numbers putting teachers under threat of redundancies. The teams were said to offer a lot of support particularly from peers. In addition the senior teachers saw supporting staff as part of their role . The *"need to have to reflect, stand back and evaluate"* was also expressed.

The personal tutor system was designed to offer the students support because many teachers felt the college could do more to provide the means to enable healthy behaviours to happen. One teacher felt *"grossly desk-bound and not as healthy as I could be".* She welcomed the Chief Executive's keenness to promote health in both staff and students indicated by a recent questionnaire sent to elicit staff wishes in this area.

Practitioners

There had been road shows at the beginning where the teachers went out to talk to practitioners. The link teachers to clinical areas had an information giving and communication role which the practitioners valued because she *"told us what she could".* Mentor study days were in existence before the DipHE. There was a conscious effort to make the college feel welcoming and comfortable to practitioners but one teacher explained that " *we do not now have time to have coffee and meet with practitioners on a regular basis - maybe that's a luxury we can't afford"* . The perceived 'threat' of the new students experienced by practitioners at the beginning of the change had been successfully reduced. There was a real effort to make the new course a shared experience with the practitioners. The practitioners were involved in joint evaluations with the students and *"have a voice".*

In the handover from the early to late shift, observed on a general medical ward there were no explicit references to health promotion activities although from listening to the report it appeared there were potential opportunities. Two of the practitioners said they tried to do health promotion particularly with diabetics but that it was not really planned. This role was (and perhaps should, they suggested) increasingly being taken over by the clinical nurse specialist. As one

staff nurse admitted: *"someone else can do it, I'd rather be saving lives"*. They reported there had not been a dramatic change with the DipHE students with regard to the health promotion abilities compared with the last 'traditional' course students who had also been health focused. The consensus was that *"we've all been brought up with health promotion anyway"*. Supervision of students was identified as a problem due to low staff numbers on the ward. Lack of time was the reason cited for not doing health promotion: *"all we've done is basic nursing care"*. The concept of taking a health promotion approach was supported however, in order that *"lots of re-admissions could be avoided"*.

Generally the hospital practitioners felt that the 'traditional' students had known more than the DipHE students who in their final ward placement were more like 'first warders'. The ward staff kept referring to 'they' throughout the interviews and discussions, when referring to the managers and the Trust Executive. There appeared to be a strong feeling of powerlessness and sense of lack of control over their own futures.

The community tutors reported the community practitioners approved of the DipHE students but that health visitors were more supportive than district nurses. Community practitioners, both district nurses and health visitors, who we spoke with, made many positive comments such as: *"they help me, the students chip in with things that add new perspectives", (they're) "much more aware", (they have a) "better knowledge base"*. The mature students were particularly praised as *"they can use their own life experiences"*. However there was still concern about where and what the diplomates were actually being prepared for and that *"NVCQ people will become what nurses were two years ago"*. One student wanted to work in the community immediately on completing her programme but the community tutors were doubtful the practitioners would accept the diplomates were ready to work in the community straight away - One community tutor suggested they needed 6 months consolidation in hospitals first However, the community practitioners suggested that employing diplomates. would not necessarily be a problem as district nurses in particular already have a supervisory role with the many 'D' grade nurses employed in the community.

The move to health was welcomed by the community practitioners but the district nurses emphasised that the majority of their client group were elderly or in the terminal phases of their illness - perhaps indicating a rather medical conception of health: *"(we) still tend to think of them as the leg ulcer etc - (although we) try not to"*. The district nurses appeared to squeeze in health promotion in between other care. Practice nurses were seen by their community colleagues as having an important health promotion role but we were unable to

interview any.

The Senior Education Manager for Child Branch identified a need for community role models in child health as the community is now the main area for nurses working with children.

Operationalisation of health within the curriculum

Within teaching

The leading role of the Mental Health and Learning Disabilities specialties in the operationalisation of health in the curriculum emerged as a hypothesis to be tested in all centres. In Centre B, individual interviews with a tutor from each of these specialities gave evidence to support this trend. For example, one of the Learning Disabilities tutors suggested they were ahead in this speciality as the 1982 Registered Nurse for Mental Handicap (RNMH) syllabus had already changed their focus to one of health and promoting independence. The Learning Disabilities team had also supported the other teams by giving lectures on topics that people were frightened of, for example, psychological, sociological and political issues. They were also able to influence the curriculum content and development as there was a member of the Learning Disabilities team on all theme teams and the specialty was represented on every decision making body at every level in the college. The rationale for the influence of this team was also attributed to the fact that there were initially more graduates in this team and the Learning Disabilities and Mental Health teachers could not take refuge in the biological sciences *"as some of the adult teachers do"* .

In Centre B however, the key movers seemed to have been the community team. For example *"as soon as there is a sniff of health the community teams are asked "*. Indeed, all the health sessions we observed were taught by teachers with a community background.

We noted interactive teaching methods were used. Students were actively encouraged to participate and most did. There was a tendency however for some teachers to use closed and leading questions such as: *"you did see that didn't you?"* . There was also a sense of a particular world view being presented despite the fact that students were being encouraged to develop a critical approach. Presentations were lively and well prepared.

One of the local community development workers does a session in the Common Foundation Programme on community development and empowerment. The models of health and health promotion used in the sessions we observed were

broad in focus and referred to the 'newer paradigm' approaches. The political significance and shortcomings of the 'Health of the Nation' White Paper were highlighted. Empowerment appeared to be used as a key concept.

There was a strong feeling that transition was still happening and that for some *"we are still in our own little themes"*. The establishment of theme teams was seen to actually prevent teachers from changing their orientation as they could be slotted into teams that fitted their current orientation. Subjects tended to be fragmented in the students' minds. One teacher said: *"(I) don't think we've achieved the integration we'd want to particularly in the Common Foundation Programme"*. Integration in the Branches was seen as easier because the focus were clients and their situations whereas *"health promotion could be the focus in Common Foundation Programme but it doesn't work that way sometimes"* . It was also suggested that the students needed to understand the disciplines and the various perspectives before they could begin to integrate them because *"before they can integrate anything, they have to know something to integrate"*. Nevertheless it was also acknowledged that making links between pure disciplines such as sociology and nursing practice was highly complex and that perhaps *"we are expecting too much of the students"* .

The teachers we spoke to who did not have an explicit health remit tended to use a narrower traditional medical/educational view of health as *"diet, smoking and looking after yourself"*. Sheer volume of work prevented teachers getting together to share ideas and achieve total integration.

The placement length had been extended from 4 to 8 weeks in order to meet evaluation criteria. Placements still tended to be 'nursing' focused due to the large numbers of students and many of the voluntary organisations in the city wanted to charge for placements. The curriculum manager said: you *"need goodwill for placements particularly if they are non-NHS, so we don't give people as much community input and experience as we would like"*. There is a lot of community development going on in the city yet such projects were not used for student placements. What appeared as community placements on the time-table were often shorter than they appeared because the students were also doing project work. According to the curriculum manager this had created problems with continuous assessment of practice declaring it *"a nightmare"*.

Thus the students were going into the Branches with less practical experience of working in the community than was ideal. We concluded therefore that although 'Community' as a concept was apparent in the curriculum document, its practical application during the branches required a higher profile than was

currently in operation. Overall it appeared that the Common Foundation Programme was community based and the Branches hospital focused.

Some of the conversion course students obtained jobs in the community after completing their programme and the course director said she would have liked to have given them more health education skills but there was insufficient time. Nevertheless the 'human skills' the conversion students acquired during the course were judged to be the kind of skills needed for a health promoter.

Students did not appear to see non-institutional placements as 'real' placements or associate what they did with 'nursing'. One teacher commented that perhaps the DipHE curriculum should be reversed and go from disease to health as there was a danger students viewed health as easy and less valuable because it came first. The role of the work placement was currently being evaluated. It was strongly emphasised that placements need to have clear learning outcomes to be successful. In the Learning Disabilities specialty, the short placements in group homes were seen as unsettling and potentially disruptive for residents .

There still seemed to be a lack of clarity about the link between nursing and health although the teachers had debated the issue at length and concluded that *"in the new curriculum nursing will be a stronger theme throughout".*

The process of integration

Specialists versus generalists

Teachers were organised into theme teams and could belong to more than one, such as Health and Research, but there was definitely a specialist approach to teaching. As one teacher commented *" you can't be expert in everything".* Most teachers are already graduates in subjects related to their theme and many are doing higher degrees. Three specialist posts were set up jointly with the 'new' University to support the 'ology' teaching. Health was not given this sort of attention. It was not clear whether this was because there was an assumption that teachers knew how to do it anyway or that the community teachers were seen as already ably qualified for this role. If health is to be the whole focus of the Common Foundation Programme it may be inferred that specialist health knowledge should not be marginalised to a few 'experts'. The new curriculum will be modularised which may further encourage specialisation and fragmentation.

The philosophy in Centre B is that health promotion should be integrated into the whole course not marginalised into discrete sessions. According to one

education manager, integration had been helped by the amalgamation of all the sites onto one location.

The conversion course students were reported to be disease orientated and part of the function of their programme was to change this by encouraging a socio-political approach . The course leader said that some of the conversion students who were community nurses, brought a refreshing perspective to the group. She had carried out a small study of registered nurses' 'conception' of their health promotion role . It was found that conversion students had a stronger view of health promotion as a legitimate part of their role than those who had not done the course.

Integrating a philosophy of health into practice

Teachers identified the importance of students having role models. According to the Health Promotion Officer, many clinical staff want a nurse who can do what they perceive as 'the work'. They *" don't care if they've got a research base, (but whether) they can actually get all these bed baths done?" (Curriculum manager) -or- "if someone is seen talking to a patient, a manager might see that as time wasted and if they are doing something physical they are busy" (HPO).*

Extra sessions on technical skills have been added to appease the clinical staff.

Education of the staff who give care and mentor the students was seen as important by the senior education manager (Adult Branch). The Health Promotion Unit run day release courses for qualified staff on health promotion skills. They aim to help staff change their perceptions from a medical model to a social change approach. One Health Promotion Officer had been evaluating these study days for her MSc Course and said *"it does seem to have quite a huge influence.. they change their methods of working".*

Powerlessness and empowerment in the context of change

The teachers in the main appeared to have a sense of ownership of and commitment to the curriculum as reflected in the following comments: *"very committed and excited, its all coming together" (Health Team Leader) and "its everything we wanted"* (Community Education Manager). The Mental Health tutor however, reported that the Senior Education Manager in post when the

curriculum was being written had not involved other staff because of time pressures. The tutor was regretful that as a result of this, the development of the 1982 curriculum had been curtailed. The teachers we interviewed did not give the impression the change had been forced on them and the current Curriculum Manager was on the original planning team.

All the Senior Education Managers were involved in planning the Common Foundation Programme. The curriculum has been altered considerably since the first student cohort in September 1991. However a word of caution was sounded in that the development of a huge college with central planning, inevitably increased bureaucracy and reduced the autonomy of individual teachers.

Effect of NHS reforms

The vision of the DipHE was generally accepted as being positive but the service provision of acute sector care in the Region is still taking most of the funds leading to a short termist attitude. Contracting and competition were getting in the way of what could have been mutually beneficial collaborative working between the College and the Health Promotion Unit in that *"we are competing really with them because* the courses we put on are similar". As discussed in Chapter 1, nursing education appears to have expanded its view to a more holistic view of health just as the government has contracted theirs, as expressed in the Health of the Nation document with its emphasis on disease prevention based on behavioural and life style changes.

Newer or Traditional Approaches

We concluded from the evidence gathered in the tutor and student interviews and in the observation sessions that the 'newer' approach to health promotion was being adopted. Social policy, environmental factors and the need for advocacy by nurses at organisational as well as individual levels were referred to explicitly. For example, students in the Common Foundation Programme identified legitimate roles for nursing in terms of lobbying for better children's play areas and against environmental pollution. This was particularly marked in terms of curriculum hours and learning outcomes in the Mental Health and Learning Disabilities Branches. However, a more 'traditional' approach crept into the Adult Branch with students reporting more lifestyle type intervention the further advanced they were on the course. Similarly, in terms of curriculum, where hours were devoted to subjects such as social policy in Mental Health and Learning Disabilities Branches, these same hours tended to be filled with

'nursing' content in the Adult Branch. Practitioners in both hospital and community appeared to have a narrow interpretation of health promotion, more in keeping with the 'traditional' approach. Nevertheless, in terms of educational input, there seemed to be a determined attempt to reflect a 'newer' approach.

CONCLUSIONS

* There appears to be general confusion amongst students and teachers regarding the relationship between health promotion and nursing and Nursing Studies and Health Studies.

* The sheer numbers of students make a creative approach to non-institutional placements difficult.

* There is uncertainty amongst the teachers as to whether health should be totally integrated throughout the curriculum or to treat it as a discrete discipline ?

* The introduction of a modularised curriculum may potentially increase fragmentation.

* The workloads of the teachers are extremely high preventing sufficient thinking and reflection time.

* The content of post-registration community nursing courses will have to change because much of the content of current health visitor/district nurse courses is covered in the Diploma in Higher Education.

* As there has been such a fundamental change in pre-registrationnursing courses with the introduction of a diploma course, it is difficult to distinguish what is attributable to the change in philosophy and what is attributable to the introduction of Diploma in Higher Education per se.

* There is a danger that in the new market style health service, the students will not be seen as a saleable commodity by the Regional Health Authority.

* The threat of the hidden agenda of the generic nurse to dominate other specialties was a particular fear for the Learning Disabilities teacher.

* Nursing has expanded its view of health just as the government as

outlined in the Health of the Nation, has contracted theirs .

* Having classroom teachers actively involved in curriculum development encourages a sense of ownership.

CHAPTER 7

CENTRE C - COLLEGE OF NURSING AND MIDWIFERY

Background

Centre C, an amalgamation of a number of colleges of nursing and midwifery is large, vibrant and progressive. It is located on five sites across a wide geographical area.

The mission of the college as stated in its curriculum document is that 'through it's belief in the intrinsic worth of individuals and by working alongside service colleagues and other educational providers, Centre C will deliver quality health focused education and training programmes and services to nursing, midwifery and associated care agencies'.

Recent responses to the changes which have arisen from the NHS and Community Care Act 1990 and the purchaser/provider approach to care delivery can be seen in recent documentation, which demonstrates a shift in emphasis and uses a market forces language.

One unifying curriculum is in use which is taught in all centres: a very difficult task, given the wide geographical areas involved, each with its own differing population and health care needs. With so many different centres it is possible that interpretations of the curriculum may vary and repetitions may occur, without careful monitoring and effective communication. The plan is to iron this out with 'harmonisation' and proposed centralisation in 1996 when timetabling will occur centrally.

In all sites combined, the college facilitates about 300 pre-registration students each year, in two intakes of between 150-170. There are just over 200 teaching staff, approximately 30% of the staff are educated to Masters' level and 64% have first degrees.

An equal opportunities approach is taken. The RGN/Adult Diploma in Higher Education (DipHE) programme has about 82% females, the RNMH/mental handicap DipHE about 70%. Mental health courses have more males with 58% males, whereas child and midwifery courses are taken by approximately 99% females.

Specific aspects of the Equal Opportunities policy includes the principle of

flexible patterns of work and endeavours continue to promote a wide ethnic mix in new recruits.

All programmes are showing a gradual increase in the ages of entrants.

RGN/Adult has 22% in the 25 - 34 age group and 15% over 35.

RMN/Mental Health has 20% in the 25 - 34 age group and 18% over 35.

RSCN/Child has 28% in the 25 - 34 age group and 20% over 35.

Midwifery has 58% in the 25 - 34 age group, 17% over 35 and 22% in the 17 - 24 age group.

The college services a wide and disparate area including individual cities and rural landscapes. The region has been particularly vulnerable to the economic recession and has large numbers of unemployed men and women in its catchment area.

In 1993, a conference took place entitled - the 'Fit for Purpose?' Conference. Lecturers and practitioners got together to discuss and debate the new changes in nurse education and its implications for clinical practice. The conference highlighted practitioners' worries about changes in the nurses' role. Initiatives such as these will enhance relationships between education and service, so that students can be free to learn within a unified and cohesive profession.

'Top-up' courses are provided by the college for up to 5 days per year to update and educate staff on all changes particularly those associated with the DipHE.

THE INSTRUCTIONAL SYSTEM

The first intake for The Diploma in Nursing Studies began in January 1990 and the Project 2000 DipHE curriculum - 'A New Preparation for Practice' was designed by a team of 22 lecturers plus other co-opted members.

The curriculum planning group's terms of reference included:

1. to develop the curriculum framework;
2. to plan the overall course design;
3. to prepare course components;
4. to identify learning outcomes through the design of an assessment strategy;

5. to determine course evaluation strategies;
6. to determine curriculum implementation and review machinery;
7. to submit course proposals for validation.

Influences on the curriculum included central government policies and legislation and the Health and Local Authorities strategic plans plus many other pertinent directives and policies.

Peplau (1988) is the nursing model which the curriculum encompasses and nursing is seen as "a dynamic interpersonal process which aspires to promote, maintain and restore health". The WHO definition of health is expanded upon in the college's mission statement:- 'It is a concept without fixed boundaries and implies forward movement towards a creative and constructive individual member of society. Health is a relative state and is affected by personal values, culture, society and political ideologies. It is determined by the ability of the person to set realistic and meaningful goals and to mobilise resources to attain them. Health therefore, is the purpose of all nursing behaviours'.

Health promotion is seen in this curriculum as a broad based activity, integral to nursing care, encompassing many perspectives. It would appear to be in harmony with national and international policy and nursing guide-lines.

The Common Foundation Programme is 78 weeks long and comprises 34 weeks theory, 34 weeks practice and 10 weeks holiday. There are 5 units of learning and the course is based upon biological, sociological and behavioural sciences. The key themes of Person, Health and Health Care, Environment and Society and Nursing are viewed from an holistic perspective. Four stages in learning are proposed: orientation and identification which occur during the Common Foundation Programme and application and resolution which take place in the Branches.

Unit 2 is concerned with the major concepts of Health and Health Care and occurs from week 8 - 18 as theory and 19 - 26 in clinical placements in institutional and non-institutional settings.

Students begin in Unit 1, for the first 7 weeks, addressing the major concepts of Person and Environment by examining the courses' key components.

1. Biological Sciences
2. Communication
3. Personal Development
4. Philosophy and Ethics

5. Psychology
6. Research
7. Sociology and Social Policy

These components recur throughout the course and many of them provide excellent opportunities for the integration of a philosophy of health and concepts related to health promotion as can be seen from the indicative content.

The unit devoted to Health and Health Care has the following key components, Health and Health Care is linked with nursing.

Health and Health Care
8. Health promotion and health education
9. Politics of Health
10. Sociology of Health
11. Therapeutic Modes

Nursing
12. Applied Biological Science
13. Interpersonal Relationships
14. Ethics
15. Management
16. Nursing Practice
17. Nursing Theory
18. Professional Development/Issues
19. Applied Psychology
20. Applied Research
21. Therapeutic Roles

Health promotion and nursing are explicitly linked and the concepts appear integrated and inter-dependent. The therapeutic modes component is included which in this unit introduces the exploration of different conceptual approaches to health, in aspects of care and curing from the popular and folk sector.

Nursing Practice is introduced in this unit, which potentially enhances the students' sense of identity and confidence.

Various other components in this unit contribute to developing the health promotion role of the student, including nursing theory, applied psychology, ethics, interpersonal relationships, sociology and politics of health.

In part two of the Common Foundation Programme, when students move from

orientation to identification, health promotion and health education do not appear as a component in Unit 3(a). However, other components included are relevant: communication, personal development, psychology, interpersonal relationships, philosophy and ethics, nursing practice and theory. The biological sciences always indirectly contribute to the nurses' knowledge base for health promotion and is a component which occurs throughout the course.

Health promotion and health education are a large part of Unit 4 and the personal growth and development component of Unit 5 is central to developing health promotion skills.

The reading lists for the Common Foundation Programme all contain many relevant and current texts on health promotion and health education. It is evident that health promotion is being integrated with topics such as nursing theory and practice.

Although the majority of the components in the Common Foundation Programme are central to health promotion and a philosophy of health, 30 hours labelled as health education and health promotion are timetabled: 15 hours in Unit 2 and 15 hours in Unit 4. One reason why more hours are not allocated directly to the topic may be because it is integrated by lecturers reinforcing and emphasising the health promotion component of each specialty.

The content for the health promotion and health education component is predominantly educational and medical model - traditional paradigm approaches. There is far less evidence of the 'newer' paradigms of advocacy, mediation, negotiation and developing a community action awareness.

These topics may appear in other components and it is essential therefore they are integrated into the body of knowledge labelled by the nurse as health promotion or health education.

The total number of hours actually labelled as health promotion or health education receives about the same amount of time as other components. If the health components of disciplines such as communication or sociology for example were explicit, then taken over all, the philosophy of health theme within the Common Foundation Programme would be very strong.

The Branches - Adult, Child, Mental Handicap and Mental Health.

There are five units contained within the Branch Programme and they all

continue with the key components from the Common Foundation Programme. Five components are common to all Branches, these are: Personal Development; Research; Nursing Theory; Professional Development and Issues and Management.

The amount and content of the health promotion and health education component varies considerably in the Branches. The Mental Handicap Branch allocates 51 hours to the labelled component of health promotion and health education. Adult Branch allocates 36 hours, Mental Health allocates 29 hours and the Child Branch 30.5 hours.

All Branches have a diminishing time allocation over the 18 month period, so that in the final module the time set aside for health promotion decreases to two hours.

A considerable amount of the time allocated to health promotion was devoted to resources and information technology.

In the Mental Handicap Branch, although a large proportion of time was allocated to health promotion, the perspectives taken were purely medical model preventive approaches or a social education perspective. There was no evidence of the progressive paradigms. The reading lists under the heading health promotion were all devoted to special educational needs. Much of the Mental Handicap curriculum is concerned with social and political aspects of care, advocacy, negotiation, equal rights, community care. However, when required to write a curriculum denoting the health promotion content, only medical model preventive and education models appear.

Similarly, in the Mental Health Branch the content of the health promotion component is mainly medical model and rehabilitation or aspects of the role of the nurse. There does not appear to be time devoted to developing nursing strategies for promoting mental health. If this occurs, it is not happening in the health promotion and health education component. Alternative and complementary therapies are not recognised as promoting psychological wellness, indicating that a medical model predominates in the curriculum. Many Mental Health curricula are leading the way for nurses in terms of the newer paradigms incorporating social and political aspects, advocacy and community action. Unless the students perceive these features to be part of their role in promoting health, then they will continue to interpret their role in health promotion as individual, advice giving, behaviour change approaches. There are no references to health promotion texts on the reading list.

The Child Branch took a medical model interpretation of health promotion and health education. The reading lists did not include any general health promotion texts yet included texts on developmental screening. The content was orientated to a preventive medical model: prevention of accidents; screening and safe lifting. Unit 8 demonstrated a good integration with concepts of nursing. However, the emphasis was predominantly individual, lifestyle approaches. For example, indicative content for one of the units read 'compliance regarding dental and personal hygiene'. The use of the term compliance indicates that the patient might be yielding under pressure, or being persuaded against their will and denotes a medical 'top down' approach rather than a collaborative partnership approach.

Although the Adult Branch devoted more time to the health promotion and health education component, the content was mainly educational and medical model. Other aspects of health promotion were included in key components, such as ethics, nursing practice and theory, politics of health and sociology of health. The importance of an approach, which integrates all aspects of health promotion and a philosophy of health within the student's body of knowledge has become increasingly apparent.

Direct Entry Midwifery Curriculum

The nine units comprising the direct entry midwifery curriculum are organised using a different structure to the DipHE nursing curricula. This current programme has only been in progress since September 1991. It involves shared learning with the DipHE students in the Common Foundation Programme and sharing the health promotion sessions but with different placements.

There are only 20 students in each intake which is small compared with the 160 students in some DipHE cohorts. All the academic teaching takes place on the city site but students are allocated to all sites for their placements.

The midwifery curriculum differs from the nursing curricula and there is a definite emphasis on midwifery as a distinct and separate profession. The curriculum is structured around four concepts taken from a nursing model - person, health, environment and nursing (Fawcett 1984).

What are the stated aims, objectives and proposed practices contained within the course outlines and curriculum documents ?

Each unit in the programme has a varying number of topics or themes.

Units 1 and 2 take place during the first 15 weeks and are called 'Health and Midwifery' and comprise the following components: midwifery principles; biological sciences (with a practical session); educational principles; psycho-social sciences and communication.

Content is concerned with normal functioning and diagnosis of pregnancy. The theme 'Educational Principles' contains reference to Parentcraft and the 'Psycho-Social Sciences Theme' includes emotional aspects of pregnancy and dimensions of sexuality.

Unit 3 is Preparation for Parenthood. It contains the same themes as Units 1 and 2 plus three more: Principles of Management and Economics; Research and Philosophy and Ethics.

In this unit, disorders of pregnancy are introduced, alongside biological understanding of pregnancy and labour. 'Educational Principles' include the role of the supervisor of midwives, rules of midwifery, the relevance of smoking, drugs and alcohol in pregnancy, management of information systems. 'Psycho-Social Sciences' include: the family; the role of the father and the role of the medical social worker and maternity benefits.

Unit 4 is called Factors Influencing Health and Health Care in Midwifery, Experiences are offered in Medicine, Surgery/Gynaecology, with children and in the Special Care Baby Unit.

One extra theme is introduced in this unit, which is called Therapeutic Modes. The whole unit is the one most similar to a nursing unit, looking at care of those with certain medical conditions. The Midwifery Principles' theme introduces nursing theory for the first time. The 'Educational Principles' are concerned with 'health education in relation to specific medical conditions' and 'advice given to women concerning medication, work, sex etc.'

The students present a case study on a patient, plus a research article on pain in the neonate.

Unit 5 is about the Antenatal Period and contains no new themes/topics. In this unit, students present a short teaching session to peers.

Units 6 - 9 follow the time span of pregnancy, with emphasis on the intranatal period and labour, the post-natal period in Unit 7, consolidation and reflection in Unit 8 and finally, Unit 9 deals with professional responsibility.

To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application ?

There was no explicit commitment to a philosophy of health or health promotion although Fawcett's model (1984) contains relevant concepts. The integration and promotion of health concepts were implicit rather than explicit.

In each unit the most noticeable emphasis was on the biological sciences, which took the lion's share of the curriculum entries. It is not clear whether more timetable space was allocated to these topics or whether a lot more content was covered in the same amount of time allocated to other themes. For example, in Unit 5, the Antenatal Period, Biological Sciences has 31 items included, whereas Education Principles has only 5 items.

Noticeable omissions from the programme were politics and social policy, which when mentioned were included in either the Psycho-Social Theme or the Educational Theme, but did not feature heavily in the curriculum.

There was not a specific theme about health or health promotion and whilst looking for components of these issues in the other themes, it became clear from the curriculum, these issues were lacking.

There was little evidence of a body of knowledge, research or theories that contribute to enhancing the promotion of health, other than the communication theme, which aimed to enhance the midwife's ability to form a therapeutic relationship with the client, the basis for all communication.

As with other curricula, components important to a philosophy of health and health promotion were evident, but would need an integrating theme or unit to elicit the knowledge and skills so that they could be labelled as health promotion and put into practice.

The 'Educational Principles' theme briefly focused on individual advice giving, mainly to do with lifestyle issues, Parentcraft, health education in relation to medical conditions with examples from physical care such as medication, feeding and injections.

Topics included in 'Philosophy and Ethics', 'Communication', 'Psycho-social Sciences' and 'Midwifery Principles' contain items helpful to health promotion,

but they would only be perceived as such by the students if so labelled and emphasised.

Student centred activities included finding out about pressure groups - in their own time - which could indicate this was not as important as a teacher centred activity.

In conclusion it appears that the model of health and health promotion being proposed in the curriculum is of the traditional approach, as discussed by Macleod Clark, Wilson-Barnett, et al (1992): i.e. 'These traditional approaches concern themselves exclusively with physical health, disease prevention, the individual in isolation from his/her environment and a "top-down" approach to information and advice giving'.

The curriculum did not make explicit the modern approaches mentioned in the same research: i.e. 'The more modern enlightened approaches emphasise the promotion of positive health with physical, social and mental facets and educational processes, that are collaborative and participatory'.

How was the course assessed and outcomes described ?

Assessment of the course was orientated towards health and health promotion.

Placement guidelines contained seven criteria, three of which (presented below) related explicitly to health. The guidelines stated that 'in order for the student midwife to become orientated to the work of the primary health care team, and the concept of health, he/she should observe and where appropriate be involved in the following:

* health education and health promotion;
* find out the facilities provided for health promotion and health care;
* examine patterns of health, illness and disease in the community'.

Mentors were identified as registered midwives who had undertaken the ENB 997 course or appropriate preparation.

Assessment statements were provided so the mentor could make judgements about the students' performance. Concepts of health and health promotion were a strong feature of these assessments.

THE LEARNING MILIEU

Pre-Registration Direct Entry Midwifery

Interviews took place with two midwifery lecturers, a class was observed and a cohort of 10 midwifery students completed questionnaires followed by discussion.

The Midwifery Lecturers

Lecturers said the curriculum was working well, but highlighted problems with applicability to all six sites. There were only 20 students in each intake, which appeared to give them a sense of role identity, positive relationships with teaching staff and contentment, such as we found with students in the learning disabilities branch in Centre A and the DipHE Branch students in Centre D. These groups were also small cohorts.

Students were perceived by their lecturers as being very enthusiastic and progressing well - "as quickly as post-registration students in getting their deliveries in".

A distinct feeling of difference from the nursing students was transmitted. The midwifery students *"get practical experience very early on and this may enhance their sense of role and identity".*

Midwifery skills were seen by the lecturers as being largely educational, psychological and supportive and not concerned with caring for dependent patients. The students were allocated to medical and surgical wards to learn about the nursing or caring skills they would require; pain relief, comforting, alleviating distress, managing bowels, vomit, washing and feeding.

Midwifery was said to take a holistic approach involving social, emotional and psychological aspects and midwives had more professional responsibility for clinical diagnosis. The midwifery curriculum was reported to have been liberated from 'the medical model' with the demise of the Central Midwives Board. It was implied that rather than a shift from disease to health, midwifery had seen a shift from obstetric nursing to midwifery care. It was stressed there were no midwifery units in the area, so that midwives and students were still working as part of the obstetric service.

Concepts of health were discussed and the tutors demonstrated a broad understanding of health, talking about poverty, social security benefits and the

provision of school meals whilst stating they *"did not like to talk politics"*.

Examples of opportunities for health promotion included Parentcraft and preconceptual counselling.

Factors such as the rapidly changing needs of the service, lack of jobs for newly qualified staff and no vegetarian alternative meals on site militated against the lecturers considering Centre C as a health promoting environment.

The Midwifery Students

One class on 'The Psychological Effects of Surgery' was observed. This session took place in a quiet classroom, painted a restful colour, with modern tables and chairs arranged in a horseshoe.

Thirteen female students, including one from a minority ethnic group, all of whom were predominantly in their twenties, were present.

Friendly and informal relationships between students and teachers were observed. All students were encouraged to contribute and their prior knowledge drawn upon. Lecturers appeared to value the students' comments.

Students had taken an examination on the previous day and group spirits reflected this. They had recently completed placements on surgical and medical wards. They described how they saw themselves as very different from the nurses. The students viewed nurses as controlling care planning and goal setting with the focus on *"getting them (patients) out"* rather than *"getting them well"*. They also said that *"nurses make people feel that they are at school often"*.

The group evaluated their placements, particularly the medical ones, as "a waste of time". They gave no indication in the discussion that the placements had given them an understanding of medical or surgical conditions and their relevance to childbearing women.

The discussion focused on conditions rather than people, and the teachers kept pulling students back again and again to the topic of psychological aspects. Ideas about empowering clients to make choices were expressed. The students recounted anecdotes including "horror stories" about radical surgery. This finding suggests more time is required following placements to debrief and permit students to dispel their emotional traumas so that academic time is protected. This issue arose elsewhere in Centre C with the Common Foundation

students. It was observed that mature home based students do not get the same opportunities as students living in halls of residences, to discuss the day's events with peers.

It appeared from the discussion that practitioners continue to transmit to students through the day to day culture on the ward the need to maintain emotional detachment. The students may need to express their emotions in class therefore because they are repressing all forms of emotional attachment in the wards.

The students took no notes.

Questionnaires and Discussion

10 students completed Form A questionnaire (Appendix ix). Three students left to attend to domestic commitments. The others remained behind even though they had not been either prepared for or expecting to take part in the research.

Consequently responses were brief and hurried. There was no marked difference in the responses from the midwifery students and the DipHE students. Since all health promotion sessions had been shared by both midwifery and DipHE students this finding was not surprising. It was noted that the students' view of health and health promotion did not appear to have been influenced by their separate and strong professional identity.

In response to questions about their understanding of health promotion/health education, all students confined themselves to responses to do with physical health, from within a medical or educational model such as:

"encouraging people to focus on a healthier lifestyle, explaining the advantages of diet, exercise etc".

and

"(putting) leaflets and adverts in easily accessible places eg on TV, in shops, clinics, post offices etc..No smoking days etc".

Or seeing the topic in terms of:

"leaflets, information booklets, community studies undertaken by health education Councils on AIDS, violence, STDs".

and

"leaflets to inform patients of procedures, conditions".

When asked for examples of health promotion and health education in clinical situations, responses were confined to pre-conceptual education and ante- and post- natal education and giving advice. No details of content were given.

Overall the responses indicated that health promotion was not considered to be an exciting or challenging topic and answers were brief and to the point.

Theoretical assessment

Until Unit 3 the Midwifery students shared the same course and assignments with the DipHE students. Documentary evidence suggested a strong health promotion component.

Following the separation of the courses the theoretical assessments included a 2500 word assignment in Unit 3 on topics such as gender differences, uses and abuses of language in a caring profession and communication and culture. In Unit 4 there is an unseen three hour examination on the biological sciences and midwifery and nursing principles. A longitudinal case study covers the assessment for Units 5, 6 and 7 with another assessment and examination (open book) in Unit 8 and final assignment in Unit 9.

The concepts of health focus is present and students are given the opportunity to develop these themes. The assignment topics in Unit 3 indicate that overall, opportunities for the integration of health promotion exist throughout the course.

CONCLUSIONS

* There is an implicit assumption within midwifery (in Centre C and in other centres) that because midwives work with people who are not sick, they must automatically be promoting health. Normality or normal functioning is seen to equate with health. Midwives in other centres have proposed they are experienced health promoters and that their profession has always been involved in promoting health. The evidence from the curriculum and responses from students and teachers at Centre C did not confirm this view. There was no body of knowledge available or a process evident by which students could promote health or well being. The promotion of psychological health requires an understanding of psychological theory and the opportunity to apply that theory to practice.

* A strong sense of professional identity was evident.

* Good student/teacher relationships based on mutual respect and warmth were observed.

Post-registration Curriculum

We were unable to obtain the curriculum document for the Caring for People with HIV/AIDS course and so have confined our comments about this course to the Learning Milieu Section. We interviewed both the tutor and students on this course.

THE LEARNING MILIEU

The Diploma in Higher Education (DipHE) and Post-registration Programmes

The findings in this section are generated from interviews, questionnaires, discussions and observations as detailed in Chapter 3.

Interpretations of a philosophy of health

All the lecturers we spoke to were positive and enthusiastic about the shift towards a philosophy of health and it was evident that the progression in Centre C had pre-dated the DipHE with the introduction of the 1988 curriculum. Staff appeared willing and friendly and were able to devote time to the project.

A politico-socio-economic model of health was apparent from many lecturers and the concept of empowerment was seen to be crucial.

One lecturer commenting in approval of the shift said: *"yes, it improves people's lives - it's essential to help nurses to do this".*

Another lecturer told us that a health rather than an illness based approach was always taken and an interactionist perspective used.

Common Foundation Programme

The philosophy behind the Common Foundation Programme was explained at some length by one specialist lecturer in health promotion as follows:

"You can't expose students to clinical areas, which we do in the Common Foundation Programme without having to refer to disease. It's not the dominant theme but you are also working with a group of people who have come to be nurses whose perception is that nurses deal with sick people. You've also got an awful lot of teachers around who still believe that nursing is about nursing the sick ... It's health and disease. The idea of teaching health first is eminently sensible to me and we had an '88 curriculum here that looked at health and I took the health modules then and it seemed sensible to do, to then move to a project where you embedded (I say this and smile) the idea is, it is embedded in health, how far I don't know. (It's) easily chipped away I think. The idea is fine. But as I say, the preparation of teachers to change was minimal. I speak to teachers across the country and because we can teach disease orientated (curricula) and many of us, our qualifications were outside of nursing, our academic qualification, there was an assumption we could teach health and many of the people I talked to hadn't a clue what they were talking about. This claptrap 'it's embedded in health' and you'd say 'well what does that mean' teach them health components, for me that's not what it means and the idea of trying to find it within the curriculum is a nonsense, it should be in everything. We shouldn't have it labelled, its just an extension of what we were doing but how far we've got I don't know.....

"I think if you look at the curriculum, you will see the number of hours are put aside for health education and health promotion, it's very very small. I'm not saying it should be larger than that, but it seems quite an interesting thing to have done but you say, we may do this in health, we'll give 20 hours in the curriculum to it. I'm not saying that it has to be as overt as that if the philosophy is understood and actually, I'm not sure that we always do have this idea. That it's embedded in health, so the 20 hours to me is very small if you're not doing anything else. If health is involved in everything else you don't need any more because health promotion and health education....

"I don't know what health education and health promotion is but I think the idea that we begin with health and we look at the normal and that health promotion and health education are not just about stop smoking, stop drinking, it's much more than that, its about enabling and empowering and all those words that I'm bound to know because I've just done the course. But I did used to sprinkle my conversation with them before I did the course as it was quite interesting. Perhaps that's why it appealed to me.

"If you are enabling students to grow and develop then that's in a way going to rub off on them and that's all about health education and health promotion as those are the very skills you wish people to have and so if I can enable a student

to become self directed and they have acquired that skill, then they can pass that skill on in whatever way and that's what I mean by you don't have to have 80 hours of this if you just accept and acknowledge that it's part and parcel of lots of the other things that we do. My personal tutor role, I see very much as not health education and health promotion but actually helping students to develop those skills that they will require in health education and health promotion".

We include this lecturer's account in some detail because the philosophy she expressed was echoed by others in Centre C, particularly those taking further degrees in health education. It was also similar to other lecturers in other centres who had graduated from a health based nursing course or done further post graduate study in health promotion.

The importance and the social context of care and self-awareness of the students was emphasised by a lecturer running a post-registration course. He said:

"The first thing I should talk about is getting people to acknowledge that they are at risk themselves - it's not just a question of saying that this is a course about people with AIDS, clients etc. But one of the main sort of themes that I try and get across is when we are looking at say the risk to health care professionals, is to foster the idea that people need to be aware of how at risk they are in their social life and they are much more at risk of HIV in their social life probably than they are at work. Getting people to realise that it's not just a question of we are here to look at nursing some anonymous person with AIDS - its about a personal thing as well. We look at sexuality and we look at sexuality and prejudice. I get people to look at and acknowledge their own sexuality as well, so its not just a question of looking at other people. So its thinking about their own sexuality and their own sexual practices which has got to be health promotion in my book anyway. The other thing is we look at prejudice and how prejudice can affect their care and I get them to just basically, all you can do on a very short course is to get people to acknowledge that yes, maybe they behave in prejudiced ways and get them to acknowledge that. I get them to think about it. But in a way, if people can do that and realise that they might treat people judgmentally and then perhaps be aware of that and do something about it, in a way that's health promotion as well, because they may be denying people access to health care or access to certain aspects of health care that they previously wouldn't.

"The other thing we talk about in a sort of social context is looking at the ways in which, particularly related to HIV obviously, has been the campaigns in the way that the government, the DoH and local agencies have responded. I get them to look at local and national voluntary or charity groups that are involved

in prevention work. Say one course member would look at the Terence Higgins Trust - we would look at the strategies they would adopt, do they target a specific group, is that a good idea, does it work ? If it does work, how do they know it does. We look at things at a local level, we look at that's going on in the city, what's going on in the reduction of sexually transmitted diseases. Then we would probably spend some time discussing the government's response - I would very often initiate discussions, 'do you remember the old campaigns, the posters ? Do you think they worked ? - let's look at what the government did to try and stop drug users getting infected with HIV for instance - what did they do? -is there any evidence that it did work ?' And then we look at some of the places where it fell down, those problems - and analyze them in a discussion sort of a way, the reasons for that - and very often come to the conclusion that one of the reasons that early health promotion education campaigns fail was that we were being coy, we were scaremongering and not giving information. You get the idea that we were generally discussing what the government did for health promotion and HIV/AIDS.

" I know people's image of health promotion varies doesn't it, but on a course like this I have to approach it from a HIV/AIDS perspective. Of course the other thing that we do in terms of health promotion would be to look at nursing strategies that can be used with people who are HIV positive to improve their immune system. Obviously the lack of effective medical treatment for AIDS really, the role of nurses is very much at the forefront in terms of making people live longer with a better quality of life. The majority of things that make people live longer with HIV are under the nurses' sphere of influence. Reducing stress, improving diet, looking at lifestyle factors such as safe drug use for people who continue using drugs, quit smoking. All these lifestyle factors, avoiding other infections, all these lifestyle factors are behavioural factors, within the realm of nursing to do something about it, so you try and build in to the nurses that, having this thing with AIDS you never can do anything it has a relentless course.... and the way the nurse can interact and prevent that happening, a lot of people don't realise. They think it's all about giving drugs and things like that. When the majority of things that affect people's lives are nursing interventions".

We include detailed tracts of this lecturer's interview because he has identified some of the key issues pertinent to health promotion, without having taken a post-graduate qualification in health education. Experience of a particular client group, enthusiasm and motivation and opportunities to meet others in the same field at conferences has resulted in a teacher producing a course strongly featuring health promotion. Issues such as self-awareness, media representations, political pressure groups, local and national policies and profiles and **nursing**

strategies for working **with** people to improve their immune system were included (Researcher's emphasis).

Nurses working with people with chronic illnesses may automatically develop and create strategies to enhance their patients' health, without necessarily realising that what they are doing may be labelled health promotion. Indeed, this lecturer commented that the students would not acknowledge that complementary therapies such as aromatherapy could be encompassed under the umbrella of health promoting activities.

During discussions with students on the HIV/AIDS course, all experienced qualified nurses, health promotion and health education were perceived as being integrated into the curriculum. As one student said: *"It hasn't been separated out as a separate issue. We've discussed the implications, everyday a different aspect, but we haven't had a special health education input as such. I think what did come across time and time again is that they themselves (the patients) try and keep healthy."*

When specifically asked about health promotion and health education - even though it hadn't been separated out and they had been exposed to self-awareness exercises, media interpretations, political issues, pressure groups, local and national policies, their responses become medical model orientated and focused on physical health.

It became evident that despite the attitudes and knowledge they had been exposed to on this course, the students' views about 'health promotion and health education' embraced the traditional paradigms.

For example

"....so what you do is support them (the client) with information, to maintain a healthier lifestyle even though they might have HIV, to have a healthier life and ***prevention against any infections***". (Researcher's emphasis). The comment begins with the emphasis on personal support but concludes with a medical model of prevention.

A midwife on the course commented:

I think in midwifery, health promotion has been around a long time because you are dealing with healthy people anyway. It's introduced very much earlier....eg pre-conceptual care".

She added:

"You do counselling anyway in an ante natal clinic, not on the scale of HIV, but other blood tests ***you have to give them counselling".*** (Researcher's emphasis)

The language used denotes a 'top-down advice giving' approach, focusing on physical health. Preconceptual counselling is concerned with preparing the body to incubate and nourish the growing child, not preparing the parents psychologically for the rigours of parenthood and a job for life, rather than 9 months.

The sharp distinction between hospital and community was emphasised by one student. When referring to the nurse's role, she said:

"She is only going to get a chance to promote health if she's working in the community, where you see other people. But if you're working on a ward where all you've got is ill people, the only people for health promotion are going to be the relatives".

Despite exposure to other models in the course, this nurse is unable to conceptualise a role for herself in promoting the health of sick people. She is only able to articulate a health promotion role from within a medical model approach, namely in prevention, secondary or tertiary prevention or rehabilitation and one which take place in the community rather than hospitals.

Another student also demonstrates the lack of integration of health promotion concepts with the following comment:

"If you wanted to come into nursing to do health promotion you'd do health visiting. Yes, health visitors want to do a job that's promoting health".

Yet the same students within the half hour discussion made comments about supporting people with an illness - HIV - to lead healthier lifestyles. It appeared however, that a wide divide occurred conceptually, in that health can only be promoted amongst those who are already healthy.
Different approaches to transmitting the attitudes, credibility and knowledge of the course provider need to be considered so that the integration of health promotion concepts take place within the students.

In a different site the research team had one unsolicited encounter with a tutor in the coffee room, who was uncomfortable with the shift towards health and the DipHE students for the following reasons:

"students at the end of their second year don't know where their pylorus is and wouldn't even know a liver if they fell over it!"

But generally the lecturers expressed views about a philosophy of health and health promotion consistent with international policy, in line with 'newer paradigms' and with UKCC recommendations. It was noticed however, that the lecturers with higher degrees in health education or health promotion were more likely to be designing the curriculum than teaching it and those that did the health promotion teaching gave predominantly medical model examples of the practical applications of health promotion.

A Clinical Nurse Specialist defined health promotion as being about promoting healthy lifestyles and health education specific to what was wrong with a person. She also described a health promotion initiative which she led and co-ordinated which involved a public display and information service in a busy shopping centre, seminars for health care professionals and a painting competition for children. Sponsorship was arranged from local businesses. The Clinical Nurse Specialist emphasised the difficulties in motivating nursing staff to be involved and the low turn-out at health promotion seminars. She felt this was indicative of low morale, in that staff implied they were supportive of the idea but not if it involved extra work. The response from the public she noted, however was excellent.

Political and social empowerment models of health promotion were proposed by two researchers on The Health Promotion Unit's Health Needs Project and the Heart of the City Project. One researcher commented that the Health Service reforms had complicated issues for health promotion, as sometimes it was difficult to know where health promotion actually belonged - purchaser or provider. The Health Promotion Unit appeared to be working at a macro level and was involved in helping purchasers write contracts which included health promotion.

The Heart of the City Project is involved in a variety of interesting initiatives including working with local people on issues such as housing, racial harassment, smoking and diet, based on key concepts of empowerment and action. One of the primary health care workers based at the Health Promotion Unit worked with local GPs and community nurses attempting to change their perceptions from individual behaviour change approaches to ones more in favour with international policy.

Successes so far have included setting up community activity sessions such as yoga, keep fit, discussion groups, relaxation training, healthy cooking classes,

women only sessions at the local pool, shopping basket survey to encourage local shops to stock healthier foods, also help to set up a food co-operative. The community workers aim to encourage self sufficiency amongst the community and share examples of good practice with other towns and cities. The project headquarters also act as information resource centres, open to all. There is no formal link with health care providers such as the Trusts.

The students do not have any contact with these projects other than as resource centres. A lecturer from the college has a formal link with the local Healthy Cities Project of which Heart of the City is a part.

Another lecturer accompanied the research team to these interviews as a means to keeping abreast of current community initiative, consolidating links and investigating the possibilities for student placements.

Although the city has a high proportion of community initiatives within its boundaries, the students as yet have not benefited from experience or exposure to these progressive ways of working.

Preparation for a philosophy of health within the curriculum.

It appeared in Centre C that the shift towards health was more of a progression than a dramatic paradigm shift and that the impetus for change came from lecturers' interests, motivation and abilities.

'Time out' days were a feature of change and although not specifically orientated towards health, would help psychologically.

One lecturer commented on the support for development:

"*I can't fault the college one iota in terms of allowing me the opportunities to do that. I think they recognise that we are about delivering quality stuff and AIDS is such a difficult field that if you don't keep up to date, then you've blown it, you can't offer a quality package. So keeping up to date and attending conferences and study days and making sure we're giving a quality package is just as good as the actual what goes on in the classroom.*

Several staff members commented they had studied for degrees and diplomas in Nursing Studies but these courses had contained no reference to health promotion or health education.

In response to a question about staff study days on operationalising the

curriculum, one lecturer said:

"There were study days but I don't think they were geared to looking at perceptions of health etc, it was how we were going to teach this curriculum, in what way was it different and people were worried about teaching at diploma level. That occupied our thoughts extensively for so long and things like that, that we didn't get round to it. My view is that it is inadequately dealt with. But it would be... probably at the time I thought we dealt with it adequately".

Another lecturer said:

"I think we focused more on psychology and sociology. We thought if we were looking after the mind, there was a health promotion angle".

Gaining a degree in health promotion was seen as popular and useful for staff. One staff member commented *"that's where the money is and the development is going to be".*

It was noticed by lecturers that practitioners in the Adult Branch were very slow to change and traditional in their approach. It was suggested that all they really wanted was for the students to be able to get on with tasks such as dressings, injections, taking Blood Pressures. Consequently, the educational goals of the college had been compromised to meet service need.

Lecturers lamented that the medical model still predominates, and that more traditional practitioners tend to take a narrow victim-blaming individualistic behaviour change approach to health education. This view however is not dissimilar to current government policy and therefore can be seen to reflect dominant societal values.

Lecturers told us that although there had been a number of nursing health promotion posts created within the clinical areas, these posts were purely cosmetic and a token gesture. By this they meant there was a naive view held by some managers that health promotion as part of health care saved money. The Health of the Nation philosophy was seen by lecturers to support this view.

It was reported that the effects of Working Paper 10 were not yet known nor how managers would spend money in terms of continuing education. It was stated that an increasing number of qualified nursing staff were wanting to take health promotion courses, not out of general interest nor commitment to the topic but because of the concern they would be overtaken by the DipHE diplomates.

In the clinical areas, health promotion and health education were described as not yet seen as part of nursing but as an 'add on', to be done if time allowed. Little evidence of health promotion in care planning was reported.

The lecturers generally felt that using students as 'Agents of Change' in the clinical areas was inappropriate and more energies should be spent on re-educating clinical staff who should have been invested in and developed before the philosophy of health curricula were introduced.

The general consensus by the lecturers and the research team was that the nursing profession did not appear to have learned lessons for implementing a philosophy of health from their past experience of implementing nursing models and the nursing process. One member of the research team recalled a similar feel to discussions about the nursing process over a decade ago in which clinical staff saw it as something to do with students and their teachers but nothing to do with them.

The college as a health promoting environment

Staff gave mixed responses to this issue. In terms of management support for personal and intellectual development, there was a unanimous response in the affirmative. In terms of exposure to heavy workloads and deadlines and constant change, feelings of tremendous stress were expressed.

The students said the staff never appeared to have enough time for them. The research team did not have this impression. They felt welcomed and were never rushed or hurried by anybody.

A general air of agitation was noted at some sites particularly in the city. A similar atmosphere was noted at Centre B where large numbers of students are also dealt with.

In terms of the physical environment, Centre C was not considered to be a healthy place to work. Classrooms were noisy and airless and some students were taught about 'health' in former fever wards. It is possible that poor teaching accommodation may have negative consequences for students' self-esteem, assertion and self confidence which goes against the main features of health promotion.

The Process of Integration of a philosophy of health and health promotion in the Curriculum

Centre C (as have three of our four centres) opted for specialist lecturers in preference to generalists. With specialist teaching, a depth of knowledge is achieved at the cost of integration with other subjects.

It was evident that the lecturing staff responsible for writing the curriculum had the requisite skills and abilities. Some of those responsible for teaching health promotion were 'self-taught'.

Despite the broad socio-political emphasis placed by staff on concepts within health promotion, the predominant models espoused by students were medical and educational approaches, within an individual or personal framework.

The ideology students faced when on placements with traditionally educated nurses was powerful and although able to discuss health promotion in broad terms, when asked for examples tended to give medical model and educational examples. From talking to the post-registration students it appeared clinical staff were using these approaches so that students had no exposure to health care workers promoting the health of well or sick people. The early placements occurring in the Common Foundation Programme exposed students to parameters of normal behaviour but at no stage did they gain experience of promoting health, using empowering, participatory approaches.

When asked in discussions and questionnaires about their understanding of health promotion as a general concept, students were able to give comprehensive answers. When asked for examples of health promotion applied to nursing, midwifery or health visiting, examples tended to be within the medical model.

The following extracts are examples of responses on questionnaires.

"Health education takes place on 3 levels, Primary, Secondary and Tertiary. It is about informing people of how best to prevent diseases/conditions before they happen and how to cope with existing diseases/problems. Health promotion is where active steps are taken such as passing legislation to promote health". (Student at end of CFP)

And another student:

"Identification of self-care deficits and self-care abilities and nursing intervention

(a) adopt strategy to reduce/resolve deficits
(b) exploit/enhance/develop abilities
(c) education > empowers individuals to do this for his/her self".

This same student responded about opportunities for promoting health in the last placement thus:

"fairly limited, restricted by staff. Let's face it, you've got to be seen to be doing 'real' nursing haven't you? (if you want to pass your placement) What is important is that we are aware of the importance of health education and health promotion - we often don't get the chance to engage in it!" (Student at end of CFP)

Another student commented about practitioners commitment to health promotion thus: *"there's not much enthusiasm really".*

Students also affirmed that health education was part of nursing because it was necessary to help patients to become well and prevent them from developing other problems. They gave examples such as Well-Woman Clinics, screening, diet and practice nurses doing exercise classes with the elderly.

A suggestion which included psychological health came from this group:-

They proposed that the role of the school nurse could be developed into a pastoral one so pupils had someone to talk to *"so society wouldn't be in the mess it is in today".* Other examples given of the nurses' role in health promotion included teaching patients about their drugs and involving them in self-administration of medicines.

In response to questions about whether their views of health promotion had changed since beginning the course, everybody replied in the affirmative and were positive about the health promotion teaching. Overall the students said they were enjoying the course very much.

Operationalisation of health within the curriculum

There are 10 Common Foundation Programme placements including four in the Branch specialties i.e. mental health, mental handicap, child and adult branches plus midwifery. Aspects of parenting are included. The students have 17 days in each clinical placement and then have a 4 week non -institutional experience, which may be at the steel works, working in a school, 'Mothercare' or a creche. The aims are for students to experience what it is like to live, work, play and

die in the city.

The students also do a locality study or neighbourhood profile, plus a special interest study.

Placements are deliberately not with community nurses and midwives. On the one hand, the community could not cope with the large numbers - up to 117 in a group. On the other hand, the curriculum designers decided not to expose the students to approaches and attitudes of traditional staff too early.

In the Branches however, this health focus diminishes.

Classroom observations

Informal teaching methods were observed with a good rapport between students and teachers. A class with ENB 934 course members on 'Aids and Spirituality' was observed. The physical environment was unhealthy with a noisy generator in the background of a former ward being used as a classroom. The format of the lecture was interactionist and informal and there was evidence of a holistic concept of health in use with reference to well-being and the use of the WHO definition.

There was little reference to research or the health promotion literature and the noticeable use of sexist and ethnocentric language, such as students being asked to introduce themselves by their 'Christian' names, which is inappropriate for those who are not Christians. There was however an atmosphere of treating students as adult learners and with mutual respect.

A feature seen in the other centres was the negative views of qualified practitioners towards DipHE students. Part of this was to do with concepts of health - an abstract concept - being perceived as pushing out skills in physical nursing care. These attitudes were particularly evident in the ENB 934 students who one moment would be talking in a sensitive manner about their patients and the next, when asked to discuss DipHE became dismissive and negative.

Powerlessness and Empowerment in the Context of Change

Centre C teaching staff were perceived by the research team to have one of the most difficult tasks in meeting national nursing guide-lines because of large student numbers and a wide geographical area to cover. Stress levels were observed to be high, yet lecturers appeared to be using well thought out coping strategies and were managing a difficult task well.

Students were also perceived to be stressed and more efforts might be required to develop their own empowerment strategies.

CONCLUSIONS

* In terms of Meyer's (1988) criteria for the success of an integration of a philosophy of health, many of her criteria are met by the college. The consensus view from her study was that any health education component in a curriculum should:

1. be threaded through the curriculum;
2. be integrated with other subjects;
3. explore wider social and political issues;
4. emphasise the community;
5. explore learners' own values and attitudes;
6. be taught with informal teaching methods.

Issues 3 to 6 are met in the Centre C curriculum, although exploring learners' values and attitudes is difficult to achieve, especially when the tradition of the clinical culture has been to repress values, attitudes and emotions.

The community is a strong part of the Centre C experience. Ideally students should be able to observe health care workers promoting health with both well and ill people. The community action projects available in the city have not been accessed but are being investigated as potential learning experiences for the students.

The strong emphasis on health promotion and a philosophy of health need to be continued throughout the 3 year programme and specialist teachers made more aware of the contribution their discipline makes to the body of knowledge of health promotion.

* When looking at the 1984 WHO document to guide our analysis, Centre C has made significant progress towards meeting these criteria. Both an individual and population approaches were used and the determinants or causes of health and ill-health are a strong feature of the course.

  Many different approaches to health promotion are included in the students repertoire, although an individualistic approach predominates which is then reinforced clinically.

The Mental Health and Learning Disabilities Branch programmes do not seem to have developed a lead in promoting Mental Health approaches in the Common Foundation Programme.

* Negative views on the Diploma in Higher Education were expressed by qualified staff and work is required to facilitate the students' smooth integration into the profession.

* Role models competent in socio-political models of health promotion need to be utilised, so that students are not only exposed to medical and educational models.

* A philosophy of health and health promotion is represented throughout the curriculum although less so in the Branches. The representation of health promotion throughout the curriculum may not be apparent to students in disciplines such as psychology or sociology and so not seen as relevant to promoting health.

* There is some poor teaching accommodation, which will not enhance the students' self-esteem.

* There is a need to integrate pre and post registration student teaching to see a change in promoting health in the clinical areas.

* There is a need for the profession to develop a philosophy of health for nursing so as to distinguish between health studies and nursing studies courses.

* There is a need to recognise that a philosophy of health has its own body of knowledge and that addressing the 'normal' or usual functioning of people is not sufficient. Specific strategies need to be conceptualised and operationalised to actively promote health.

CHAPTER 8

CENTRE D COLLEGE OF HEALTH (in Association with a local University)

(Note: Site names are referred to by pseudonyms)

Background

The D College of Health is an amalgamation of a number of schools of nursing. A variety of pre- and post-registration programmes are offered at nine different sites (see list of courses and sites below). The main focus of our evaluation was the pre-registration Diploma in Higher Education (DipHE) programme and the Critical Care post-registration courses.

The catchment area in which the various sites are located, spans a wide geographical area, varying from isolated rural farming communities to heavy industrialised zones with steel foundries and coal mines. The decline in heavy industry over the last 20 years however, has seen a dramatic rise in unemployment.

Our main field work was carried out at the south site which together with the site twenty miles to the north formed the County College of Nursing and Midwifery before amalgamating to become part of the Centre D College of Health. The south site is located in the Teaching Centre on the ground floor of an eight storey modern hospital, due to become an NHS Trust in April 1994.

The classrooms are spacious and light, overlooking lawns. The library is small. There is no on-line computerised data base. The librarian commented on the lack of health promotion literature to support the shift towards a health based curriculum. The lack appeared to be identified as both 'generic' (i.e. few publications in the field compared with other specialities) and 'local' (i.e. a paucity of specialist health promotion books stocked by the library). There was general agreement amongst the teaching staff that the situation was improving.

The findings of a survey undertaken for the ENB, revealed that the nursing libraries in the Region (where Centre D was located) generally offered a poor service when measured against standards established for Colleges of Further Education libraries.

The librarian planned to improve the situation by working closely with librarians

on other College sites and in Postgraduate Medical and Patient Hospital Libraries in order to form a consortium able to provide an expanded multidisciplinary service.

Two to four teachers share an office. There is a common room where all gather for breaks. Coffee and tea are available on site. We followed the teachers' example and ate lunch in the hospital dining room. The food was nutritious and had been awarded a 'Healthy Eating Award'.

The practical room arranged for group work and discussion and containing a video player and television monitor, was kindly allocated to us for our sole use during the fieldwork.

We also visited the post-registration education department and general hospital on another site (Purple). Until 1992, the department had been a school of nursing conducting its own pre- and post-registration programmes. It is a compact building with staff offices, classrooms and a small library. We also interviewed staff from one of the hospital's medical wards. The 10 mile drive from the south site passed through a pastoral landscape of rolling green hills and fields.

We visited a fourth site (Brown) on our preliminary visit. It is situated thirty miles from South and took half an hour by train and another ten minutes by taxi. It again was a former school of nursing before amalgamating to become part of Centre D College of Health. It is housed in a separate purpose built block of the General Hospital. There is a library on the ground floor and offices, classrooms and seminar rooms on the first floor.

We have given the above detail to convey a sense of the large geographical spread, travelling time and institutional diversity within the newly constituted Centre D College of Health.

Student Intake

The total number of pre-registration students in the College of Health is 720, with a drop out rate 5.8% The post-registration total is 186 with a very small 2.6% drop-out rate.

Courses and Sites

The following courses are offered at nine different college/hospital sites (denoted by pseudonyms) across a wide geographical area:

Pre-Registration

Courses	**Sites**
Diploma in Higher Education (DipHE):	North/South (Since September 1991)
Common Foundation and Branch Programmes:	Brown } Commences Red } September 1993
Adult Nursing	
Mental Health Nursing	
Learning Disabilities	
Children's Nursing	(forthcoming)

NB: Common Foundation and Branch programmes all offered at each site.

146 weeks RGN	Red
146 weeks RMN	Brown/South

Post Registration Midwifery Courses

North, Brown, Purple, South, Red and Blue

Post registration Courses

Based at five different sites at Purple, Blue, Yellow, Green, and Orange.

ENB 902 - Return to Nursing for Nurses, (parts 1,2,3,4,5,6,7,8) (Purple, Blue)

ENB 923 - Developments in Nursing Care for Nurses (Blue)

ENB 928 - Diabetic Nursing for Nurses and Midwives (Blue)

ENB 931 - The Continuing Care of the Dying patient and the Family for Nurses, Midwives and Health Visitors (Purple, Blue)

ENB 939 - Care of People with Mental Handicap in Community, Residential and

Day Services for Nurses (Yellow)

ENB 941 - Nursing elderly people for Nurses (Purple, Blue)

ENB 955 - The Care of the Violent or Potentially violent Individual for Nurses and Midwives (Yellow, Red)

ENB 980 - Principles of stoma Care for Nurses and Midwives (Blue)

ENB 993 - Care of People with Mental Illness in Community,Residential and Day Services for Nurses (Yellow)

ENB 997 - Teaching and Assessing in Clinical practices for Midwives (Purple, Green)

ENB 998 - Teaching and Assessing in Clinical Practice for First and Second Level Nurses who have responsibility for teaching, supervising and assessing students in the clinical setting (Orange, Red, Purple)

ENB 100 - General Intensive Therapy Nursing (Purple, Orange)

ENB 124 - Coronary Care Nursing (Purple, Orange)

ENB 176 - Operating Department Nursing (Purple)

ENB 182 - Anaesthetic Nursing (Purple, Orange)

ENB 199 - Accident and Emergency Nursing (Purple, Orange)

ENB 219 - Orthopaedic Nursing for Nurses on parts 1,2 or 8 of the professional register (Orange)

Course Modules framework for Higher Award - (Purple, Green, Blue)

ENB 901 - Family Planning for Nurses, Midwives and Health Visitors (Orange)

ENB 904 - Special and Intensive Nursing Care of the Newborn for Nurses and Midwives (Orange)

Student Intake at South Site

The South site DipHE programme has an average intake of 30 students twice

yearly. There is a similar intake of DipHE students at North. The Practice Nurse Co-ordinator said she had to place an average 76 students in general practices from both the North and South sites, twice yearly.

We were given the following statistics for the South site:

September 1991	: 18
March 1992	: 27
September 1992	: 29
March 1993	: 34
TOTAL	: 108

The drop out rates were reported to be 'surprisingly small', with only four students in total leaving from the first two groups. Thus, compared with the other Centres we studied, the College of Health has had a relatively small DipHE student intake.

According to the College Principal, ninety per cent of the intake are recruited from the local area. Over the past three years, the number of 'mature' students in the cohorts has increased so that the students' average age is likely to be 25 than 19 years. We noted this trend during our field work. We also noted the gender and ethnic mix of the groups. Male students were present in each of the groups we observed. One tutor considered men were well represented and gave an example from a 'typical' group where they accounted for a quarter of the total population of 28 students (i.e. 25% compared with the national average of 10%). There were few black and ethnic minority students in the classes we attended. During interview, one tutor accounted for this by suggesting it reflected the relative homogeneity of the region.

Post-registration Critical Care Course student intake

The Critical Care Course with its core curriculum led to ENB 100 - General Intensive Therapy Nursing; ENB 124 Coronary Care Nursing; ENB 176 Operating Department and ENB Anaesthetic Nursing. The proposed date for the first intake with a twice yearly frequency was March 1991 with between 4 and 8 students in each speciality and an overall total of between 16 and 28 students.

The five year validation requested from the ENB for the post-basic programme had been superseded by the introduction of the Higher Award. We met students from the Accident and Emergency Nursing ENB Course 199 which was a

specialist module of the Higher Award.

As a sampler, we describe the demographic characteristics of the ten students we met. With the exception of one male student they were all women with an age range of 20 - 50 years, mainly in their mid thirties to forties and no-one from an ethnic minority group. The majority appeared to be from the local area. We did not confirm whether the demographic characteristics of the group were representative of the post-registration student group as a whole.

Teachers

There are a total of 121 teachers across all the College sites. During our preliminary visit, we met the Principal who is based at Brown. The Head of Project 2000 who arranged our visit was off sick during our field work. The Head of Mental Health Branch was also on sick leave. The Head of Continuing Education had sadly died the day before we arrived. We were extremely grateful and appreciative to her colleagues who still agreed to meet with us.

In the group discussions we met three post-registration teachers from Purple and eight members of the Common Foundation Programme, Adult and Mental Health Branches from South. We also met others in conversation (2) in passing (2 - Mental Health and Learning Disability) and during classroom observation (2).

All the teachers we saw during the fieldwork were white except for one who was Asian. There were five men. The age of teachers varied from mid thirties to late fifties/early sixties, with the main group in the mid forty to fifty age range.

Our data collection took place against a background of meetings to discuss the new management arrangements associated with the College amalgamations. The Principal was leading these meetings. As we understand it, a management board for the new amalgamated college had recently been formed under the direction of the principal as Chief Executive. (The changes were very recent as indicated by the designation used on the letter heads. For example, a letter dated 28 May used the term Principal. A letter dated the 9 July used the term Chief Executive for the same person).

The Board consisted of nine Directors including a new post of Director of Corporate Planning. A number of teachers told us that because of the amalgamation, two programme heads (such as for the Common Foundation

Programme) were competing for one of the new Director's posts. They saw a number of implications arising from this change. Firstly, there were going to be a number of disappointed senior members of staff who would not be appointed to the new Director posts. Secondly, most teachers were likely to find themselves with new colleagues and/or 'bosses', some of whom would be from other sites and hitherto unknown.

Thus, there was a general atmosphere of change and uncertainty. For example, we observed one teacher who was visiting from one of the other sites. It became apparent that until recently he had been located at South and he spoke nostalgically for his old base.

Already, some of the pre-registration teachers had transferred to South from Purple within the past year and so had not been working together long as a team. Others had slotted into the DipHE programme from the traditional courses when vacancies were created by teachers leaving.

One teacher told us she and the librarian were unusual in that they had been based for over twelve years at South. They were the longest serving members to be continuously located in the same place.

The teachers were involved in their own education and a number were undertaking or had completed courses at certificate and diploma level, in teaching and health education. There were also teachers completing Bachelors degrees. At least one teacher we met was hoping to pursue a Masters programme in Education. The Health Promotion Officer had been accepted for a Masters degree in Health Science and Health Promotion at a local University.

The librarian reported an increased awareness of the need to undertake literature searches and reviews by both teachers stimulated by their tutors' courses and students undertaking assignments. She had been surprised at the lack of variety in the topics selected by students for their health assignments. Common topics included diet, acre of feet and teeth and heart disease, indicative of a individualised, lifestyle approach to health promotion.

Little research activity was reported, other than teachers' project work associated with higher education (Bachelors, Masters, Certificates). The librarian gave examples from the projects she knew about including her own study on library indexing; one on stress within nurse education; another on the management and impact of change; and one on skin cancer. The librarian attributed the limited research activity to the lack of a research specialist on the teaching staff and

only tenuous University links.

The librarian could only recall one member of the clinical staff, a staff nurse, who had undertaken research other than for a course. She did not find this too surprising given that clinical staff could only use the library for reference purposes and did not have lending rights. This situation neither encouraged research nor the use of the library by the clinical staff independent of course work.

SAMPLE AND METHODS

A purposive sample of settings and subjects identified by the researchers as being able to provide specific information and insight required for the study were selected.

The Selection Process

Decisions for the final selection of our sample and associated data collecting activities were taken by a local staff member(s) designated by the College Principal, following general orientations from the research project leader. We were fortunate to have the collaboration and help of the Head of Studies, DipHE and a teacher from the Post-Registration Education department. The main focus of our study was the pre-registration DipHE programme and the Critical Care post-registration courses.

We recognise that our samples in Centre D, as in other centres, represent the designated staff members' understanding of the project and the willingness and availability of particular teachers, students and clinical staff to participate during the data collection period.

Our principal fieldwork setting was South Site where a DipHE programme had been initiated in September 1991.

Our sample included the following groups: course providers, course consumers and clinicians from whom we sought to investigate how they perceived the process and outcomes of implementing a programme based on a philosophy of health .

Course providers

The College Principal (during preliminary visit only)

Eight DipHE teachers Common Foundation Programme generalists, Branches and specialisms: Learning Disability, Mental Health, Adult; Midwifery (7 in general group discussion; 3 in 2 interviews)

Three post registration teachers: Post registration Coronary Care Unit, Intensive Care Unit, A/E, Anaesthetics and Theatres and Higher Award (1 in both general and specialist group discussion).

Practice Nurse Teacher and Co-ordinator involved in Health Studies diploma, DipHE student placements and encouraging post-registration education for Practice Nurses (1 interview).

Health Education Officer: Look After Yourself (LAY) courses (1 interview)

College librarian (General group discussion and 1 interview)

Course Consumers

36 DipHE pre-registration students:

One discussion group with 28 students in Unit 5 (September 1992) who also completed and returned 28 questionnaires on the integration of a philosophy of health within the curriculum. One group discussion with eight students from September 1991 in Adult and Mental Health Branches (Unit 7).

10 post registration students/practitioners:

Seven post basic students drawn from the Critical Care Nursing Course and three students from the Accident and Emergency Nursing ENB Course 199. The students were divided into three discussion groups.

Clinicians:

Medical Ward at Central Hospital: 3 members of staff - senior sister, sister and charge nurse.

Classroom observations:

March '93, Unit 2: Children with special needs;
September '92 Unit 5 (Overview of Diverse Nature of Nursing):

Revision session: nervous system (end of session only)

'Back of the shop activities':

Coffee room; car journeys

As in other centres, the curricular review included (i) an examination of the instructional system and (ii) an exploration of the learning milieu.

In order to undertake the curricular review, the following data collection methods were employed:

1. Documentary analysis

Course outlines and curriculum documents were examined to elicit the stated intentions, aims and proposed educational practices. Assessments and outcomes of the courses were also examined.

The extent to which the curricula reflected the WHO (1984), UKCC (1986) documents and Statutory Instrument 1456 (Great Britain.Statutory Instrument, 1989) referred to in Chapter 4, was considered.

2. Semi-structured interviews with course providers.

3. Semi-structured interviews, questionnaires, focus discussion groups with course consumers i.e. pre- and post-registration students.

4. Semi-structured interviews with qualified practitioners.

These interviews, questionnaires and discussion groups enabled us to elicit how the participants perceived the process and outcomes of implementing a programme based on a philosophy of health and to test emergent hypotheses against their opinions. (see Appendices v - x for exposition of tools used)

THE INSTRUCTIONAL SYSTEM

Documentary analysis

In our documentary analysis of the curricula and associated documentation, we asked the following questions:

1. What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents ?

2. To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application (as contained in timetables and placement information).

3. How was the course assessed and outcomes described (ie on what basis was the 'success' or 'outcomes' of the curricula judged) ?

4. How did the curriculum compare with the WHO and UKCC guide-lines referred to in Chapters 2 and 4 ?

Two curricula were examined:

The 1991 Diploma in Higher Education (DipHE) curriculum of the North and South Sites of the County College of Nursing and Midwifery (amalgamated as constituent colleges of Centre D College of Health, April 1993)

The 1991 Critical Care (Post-registration) Nursing Course with Core Curriculum leading to:

ENB 100 General Intensive Therapy Nursing
ENB 124 Coronary Care Nursing
ENB 176 Operating Department Nursing
ENB 182 Anaesthetic Nursing

This section includes a review of extracts from the Higher Award Document on the Health and Health Promotion Core Module and Specialist Accident and Emergency Nursing Module (ENB Course 199).

DIPLOMA IN HIGHER EDUCATION (DipHE) CURRICULUM

1. What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents?

Course Philosophy: The role of the nurse was identified as involving

promotion of health and provision of care through the acquisition of cognitive, affective and psychomotor skills, which underpin the 13 UKCC Outcomes (see Chapter 4). The philosophy also stressed the importance of adult learning to encourage students to be "analytical, adaptive, reflective" and teachers to be co-ordinators/facilitators of learning. The section concludes students should be "assisted to perceive the development of the individual and to consider biological, psychological, social and environmental factors which cause handicap or ill-health".

The curriculum model/framework: The principles of the cultural analysis approach advocated by Skilbeck (1984) and Lawton (1983) cited as having informed the DipHE curriculum. The approach was said to provide a 'sound basis for the development of the core elements within the Common Foundation Programme' and 'flexibility of design and content in response to the changing role of the nurse within society'. Bruner's (1963) notion of the spiral curriculum was also referred to in terms of 'revisiting aspects of learning at a higher level'.

The curriculum model being adopted reflects a commitment to an integrated approach to the teaching and learning of nursing. Students' learning was to be considered with reference to Bloom's taxonomy (1956) related to Rule 18A and outcomes (see Chapter 4).

2. To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application (as contained in timetables and placement information).

The curriculum is organised around the ENB's 5 concepts defined by the ENB in the DipHE Guidelines (1989). These are: development of the person as an individual; society; health; health care; nursing . These concepts are used as the basis for seven themes which are as follows: personal and professional development; health care systems; research; communication and social interaction; ethics; acquisition of practical nursing skills; learning and teaching.

These themes recur throughout the Common Foundation Programme and continue within the Branches. It is assumed that the themes correspond to the 'core elements' referred to in the curriculum model. The rationale to organising the curriculum in this way is to prevent fragmentation of learning and promote assimilation of knowledge and acquisition of practical skills.

Below follows an outline of the course structure from the curriculum document.

Firstly we examine and comment on Units 1 to 5 from the Common Foundation Programme followed by the Adult, Mental Health and Learning Disabilities Branches.

COMMON FOUNDATION PROGRAMME

The CFP is divided into five Units as follows:

Unit 1: Concept of health and maintenance
Unit 2: Normal human development from conception through to puberty
Unit 3: Individual development from adolescence to senescence
Unit 4: Nature of physical and mental health and handicap
Unit 5: Overview of diverse nature of nursing

Each Unit is ten weeks each with the numbers of practical placements building up to six weeks in Unit 5.

With reference to Units 1 and 2, and the extent to which a philosophy of health was evident and integrated within the curriculum, the following more detailed information was obtained from the curriculum document and timetables.

Unit 1 was expressly devoted to the 'concept of health and maintenance'.

In this unit, the students were to be introduced to each of the seven curriculum themes thereby providing a foundation for their development in subsequent units.

Throughout the unit, the student was to explore the concept of health and its maintenance as a 'necessary precursor to developing an understanding of the nature of ill-health and handicap'.

Placements, aims and learning outcomes gave clear indication of this commitment as discussed below. Placements were to include visits to 'organisation which directly or indirectly promote or maintain health' and visits to cover 'a wide spectrum ranging from statutory provision through to individual responsibility for health'. These were identified as: Health Education Council; Fitness Clubs and Gyms; Well woman/man clinics; Environmental Health departments; Public services.

Taking Unit 1 as an example of how the theoretical content of the course was to be integrated it appeared that each of the concepts and themes were developed and elaborated within each unit. In the Health Care Systems Theme for example,

students were to 'explore definitions of health and society's provisions for it's maintenance' and 'understand how a variety of factors (biological, psychological/sociological and spiritual) interact in the maintenance of optimum health'.

In terms of learning outcomes in relation to these aims, students were expected to be able to:

'Discuss various definitions of health'; 'Investigate and describe facilities available for health maintenance within a negotiated area'; and 'Recognise the interaction of biological, psychological/sociological and spiritual factors in sustaining wellbeing; Outline theories of human development and functioning; Discuss environmental social and political influences on health; Recognise the contribution of research to health maintenance; Identify statutory and non-statutory agencies involved in health maintenance'.

These outcomes indicated an orientation towards non-institutional placements and a 'new paradigm' approach to health away from individualism and lifestylism.

Students were also expected 'to appreciate the need for health education' and achieve the following learning outcomes: Assess own health status; Devise a programme for personal health maintenance; Participate in health education activities.

Theoretical Content supported the unit aims and learning outcomes and was indicative of an integrated inter-disciplinary approach. The subject titles included: Definitions of health; Structure and function of the human body and maintenance of homeostasis; Functioning of the individual psychological make-up; Political influences on health; Agencies involved in health maintenance; Assessing health; Health Screening. These latter titles suggested a more medically orientated approach to health with the emphasis on preventing disease.

Acquisition of practical nursing skills was another theme with an expected learning outcome incorporating 'the principles of promoting health' with a traditional nursing role of maintaining high standards of personal hygiene'.

Timetables (covering an eight week period) revealed that students undertook the following activities specifically related to health.

Neighbourhood Profile: Eight hours of classroom discussion and preparation;

two half days in the field "exploring their selected neighbourhood"; one day presentation followed by a concluding session of one and a half hours.

The Look After Your Self Programme began in the second week of Unit 1 and continued for six half days over six weeks.

Visits to observe food handling, health maintenance, nuclear power industry began in Week 4 and were closely accompanied by theoretical sessions and evaluation.

From Week 6, students were placed in General Practice and visited water treatment plants and sewerage works.

On examining the Unit 1 timetables it appeared to us that the session titles were not always explicitly linked to the five ENB concepts (development of the person as an individual; society; health; health care; nursing) nor the seven themes (personal and professional development; health care systems; research; communication and social interaction; ethics; acquisition of practical nursing skills; learning and teaching). The following examples of session titles, illustrate our point: 'The nature of nursing'; 'The development of nursing historical perspectives'; 'Introduction to Information Technology'; Biological systems'.

Two inferences may be drawn from this observation. One is that during the sessions the teachers made the connections between the titles and ENB concepts for the students. The other is that the students were able to make their own connections during the sessions by referring to their personal curriculum document, received at the start of the CFP which assisted them to integrate concepts and themes for themselves.

In Unit 2 students were placed in maternity care and child care settings such as nurseries and in schools/residential homes for children with learning difficulties. The rationale was to enable all students whatever their chosen Branch to get the full range of nursing experiences from an early stage in their education. They also spent a short placement with the health visitor and school nurse.

During this unit, students had classroom sessions to accompany their placements including the following sessions associated with health: the cost of child rearing; mother, infant and child health screening; the Children Act.

Classroom time (one day) was also allocated for the preparation and presentation of 'Health related topics'.

Unit 3: Individual development from adolescence to senescence.

From the curriculum document further evidence of the integration of a philosophy of health into the curriculum was provided from the statement that students were to visit 'community services which complement and support health maintenance and promotional activities'. We were also informed that students were allocated to elderly residential settings including private nursing homes.

Units 4 (Nature of physical and mental ill health and handicap) and 5 (Overview of diverse nature of nursing)

We were informed that students were placed in hospital settings to observe the care of physical illness. They also spent time in day care settings for people with mental health problems and learning disabilities.

In Unit 5 the curriculum document states that students are placed in four practice settings over six weeks. These include placements in each nursing speciality before they begin their Branch: i.e. adult nursing; mental health; people with learning disabilities and a placement with children.

BRANCHES

The units which comprise each of the three branch programmes are outlined below. Numbers in brackets indicate weeks of practical placements.

ADULT BRANCH

Unit 6: Care Cycle (4)
Unit 7: Ongoing Care (6)
Unit 8: Elderly Care (6)
Unit 9: Trauma (9)
Unit 10: Surgery Acute/critical care (7)
Unit 11: Medical and critical care (7)
Thirteen weeks management unit.

Additional information on Unit 8 stated that four weeks would be spent in rehabilitation settings; one week with district nurse or health visitor; one week in an unspecified setting.

MENTAL HEALTH BRANCH

Unit 6: Acute:Community (4)
Hospital care (10)
Special care (6)

Unit 7: Continuing care:
Elderly (5)
Hospital (10)
Resettlement (5)
Thirteen weeks management unit.

MENTAL HANDICAP BRANCH

Unit 6: Child with learning disabilities (7)
Unit 7: Client with Multiple Handicap (8)
Unit 8: Client with challenging behaviour (8)
Unit 9: Supporting the client at home (9)
Thirteen weeks management unit.

The Branch programmes outlined above, demonstrate that the number of units within each branch, depends on specialty. Thus, the Adult Branch has 11 units; the Mental Health Branch, seven and Mental Handicap Branch, nine units. Length of unit depends on the number of overall units in the branch. All branches conclude with a thirteen week management block. The titles of the units indicate a balance between hospital and community care, particularly within the Mental Health and Learning Disabilities programmes. Units 9-11 in the Adult programme however, suggest an orientation towards acute hospital care (i.e. Trauma; Surgery Acute/Critical Care; Medical and Critical Care). The number of weeks in practical placements, outnumber those in classroom activities.

3) How was the course assessed and outcomes described (ie on what basis was the 'success' or 'outcomes' of the curricula judged).

Taking Units 1 and 2 as an example, students were given practice outcomes (see above) as part of their formative assessments for their placements with practice nurses, health visitors, school nurses, maternity care. Students were asked to observe various aspects of the roles and activities taking place including the 'practice for health maintenance and promotion' and how each health

'professional contributed to a 'safe environment'.

Each student was allocated a facilitator/assessor in the practice setting to ensure they achieved their outcomes. The facilitator/assessor was expected to be a Registered Nurse ideally with ENB Course 998.

The curriculum document also stated that a formative assessment for Unit 1-5 would include group work and a journal diary.

Summative Assessments related to health (refer to outcomes outlined above):

Unit 1 The Neighbourhood Profile

In Units 2 and 3 the students were asked to undertake a 3000 word study related to health based on 12 criteria. Criterion 2 asked students to define health; criterion 6 asked for an outline of the nurses' role in promoting health. (We heard that some students in the first cohort had failed this assessment and that the importance of clarifying the criteria on which they would be assessed had been identified by the HPO).

In Unit 4 students gave a group presentation on the 'Factors which inter-relate to cause physical or mental ill-health or handicap'. They were asked to 'negotiate the health deficit area' with their course teacher.

The course philosophy of the DipHE states that throughout the three year programme, students will develop cognitive, affective and psychomotor skills which underpin the UKCC outcomes (a-m) as stated in statutory instrument No.1456, 1989, Rule 18A (see Chapter 4).

By the end of the Common Foundation Programme - students are expected to achieve Outcomes a - i.

Outcome (g) specifically states the student should achieve 'the identification of health related learning needs of patients and clients, families and friends and to participate in health promotion'.

During the Branch programme they expected to achieve Outcomes a - k.

During the management programme the students are expected to achieve the final two outcomes (l) and (m).

4) How did the curriculum compare with the WHO and UKCC guidelines?

The influences on the curriculum identified by the steering committee were represented diagrammatically within the submission document. The following official documents were cited: A New Preparation for Practice (UKCC, 1986); A strategy for nursing (DH, 1989); Working for Patients (1989); Griffiths Report II (Community Care) (1988). No documents associated with influences such as 'Health promotion'; 'Ideological transition from disease to health' from either national or international sources were cited.

The curriculum is organised around the ENB's 5 concepts defined by the ENB in the Project 2000 (DipHE) Guidelines (1989) as outlined in section 2 above.

Comparison to the UKCC recommendations (UKCC 1986)

UKCC's Project 2000: A New Preparation for Practice and Rule 18A: Competencies

The Course philosophy for the Project 2000 (DipHE) states that throughout the three year programme, students will develop cognitive, affective and psychomotor skills which underpin the UKCC outcomes (a-m) as stated in statutory instrument No. 1456, 1989, Rule 18A as outlined in the outcomes section above.

The competencies are broad and demand a programme that will facilitate the student to make connections between health and society, politics and culture, use literature and research, emphasise communication, view the patient/client holistically throughout the life cycle and work in multidisciplinary teams.

The curriculum content, placements and assessments appear to be organised in order to achieve the competencies and implement the UKCC's recommendation in Project Paper 9 (1987) that 'upon registration the new nurses will be able to practice in both non-institutional and institutional settings'. Health remains a strong theme throughout the curriculum.

LAY is an important cornerstone on which students' theoretical understanding and practice of a philosophy of health is based. Associated concepts include communication, teaching and learning.

The 1986 UKCC guidelines (1986) stressed that the CFP must be 'embedded in health not in illness' (p. 46) and that the students must learn about normal living

and appreciate that care is not always about practical activities. Placements were to be wider than traditional community placements including the work place. The Centre D College of Health curriculum appeared to have gone some way towards achieving both the theoretical and practical aspects of these recommendations. It should be noted however that the DipHE had been running for less than two years and the later units had still to be implemented. It would be over a year before the first diplomates would graduate from the programme.

The recommendation for shared learning with other health care professionals did not seem to have taken place as yet. There was no midwifery branch but an active decision had been take to include Maternity Care early on in the course (Unit 2) and not reserve it exclusively for the adult branch so that all students (irrespective of branch) could profit from this experience.

The 1986 document also recommended that each registered practitioner should be able to practice in a variety of settings and have an awareness of a broader range of health and healing than traditionally found in hospitals. The curriculum to date appeared to be committed to this view and as will be demonstrated below in the section on the learning milieu, was on the way to implementing this recommendation.

Recommendation 22 suggests that 'joint professional and academic validation should be pursued. This appeared to be happening as the curriculum document stated that diplomates of DipHE could proceed to a degree in Health Studies (Nursing) of the local University. An ordinary degree could be obtained after 2 years part-time study plus 6-12 months part-time study for Honours.

Comparison to the WHO discussion document on concepts and principles of health promotion (WHO 1984)

The 1978 WHO definition of health is referred to in the curriculum document as an 'holistic' concept encompassing 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. The curriculum reflected the spirit of this definition. The ideology purported in the more recent WHO (1984) discussion document was implicit rather than explicit.

POST-REGISTRATION AND HIGHER AWARD CURRICULA

The 1991 Critical Care (Post-registration) Nursing Course with Core Curriculum leading to:

ENB 100 General Intensive Therapy Nursing
ENB 124 Coronary Care Nursing
ENB 176 Operating Department Nursing
ENB 182 Anaesthetic Nursing

This section includes a review of extracts from the Higher Award Document on the Health and Health Promotion Core Module and Specialist Accident and Emergency Nursing Module (ENB Course 199).

1) What are the stated intentions, aims, objectives and proposed educational practices contained within the course outlines and curriculum documents?

In order to identify the above we examined the following sections of the Critical Care Nursing curriculum document.

Course Philosophy: Nursing was described as a humanistic activity in which patients had rights as informed participants in their care. Yura and Walsh's (1978) definition of nursing was supported. Yura and Walsh identify the nurse as contributing to the 'maintenance of optimum health' and involved in support, communication, teaching with clients and their families.

The ultimate goal of the course was to 'develop competent, critical thinking, empathetic nurse practitioners'.

Education was seen as a lifelong process which went beyond professional to include personal and social development.

A variety of teaching and learning strategies based upon adult education principles were to be employed and the teacher-learner relationship was to be one of partnership and negotiation.

Students' learning was to be considered with reference to Bloom's taxonomy (1956) and the development of 'critical reflection'.

A thematic approach to the curriculum was adopted to facilitate 'the incremental development' of each theme according to specialty. Health was one of ten themes considered to be 'essential key concepts'. These themes are:(1) Communication; (2) Holistic care; (3) Health; (4) Research Appreciation and Application; (5) Teaching; (6) Ethical, legal and political issues in nursing; (7) Management; (8) Maintaining safety; (9) Personal and professional development; (10) Technology systems.

The curriculum model/framework: The principles of a situation analysis approach was cited as having informed the post-basic curriculum. The approach was said to examine the learning needs and available resources necessary to prepare the curriculum. The process as well as the product of education was seen to be of equal value.

The language used to describe the course philosophy and curriculum framework as with the DipHE (see above) is in line with a philosophy of health in that it is enabling and holistic. 'Health' is seen as one of ten core elements to be developed incrementally, suggesting an integrated approach to the teaching and learning of nursing.

2) To what extent is a philosophy of health integrated within the curriculum as evidenced by the theoretical content and practical application (as contained in timetables and placement information)?

As stated above, health is one of ten themes identified in the Post-basic courses which are considered to be 'essential key concepts'. These themes are:(1) Communication; (2) Holistic care; (3) Health; (4) Research Appreciation and Application; (5) Teaching; (6) Ethical, legal and political issues in nursing; (7) Management; (8) Maintaining safety; (9) Personal and professional development; (10) Technology systems.

The most weight as indicated by the number of allocated teaching hours to each theme was given equally to themes 1 and 6 at 25 hours each (see attached). Least teaching time was given to themes (5) and (10) at 13 hours. Health was given a middle weighting with the remaining themes of approximately 20 hours each. ITU and CCU students could expect an extra two hours dedicated to the theme, reflecting perhaps their greater potential for face to face health promotion with patients compared with their colleagues working in theatres and anaesthetics.

There appeared to be support for the health theme from a number of allied themes such as (1), (2), (6) and (8). This conclusion was drawn from the theoretical content suggested for each. In theme 2 for example (holistic care) includes 'social theories', theme 6 (Issues) includes the Black Report and Government documents on health care. Theme 8 (Safety) refers to the Health and Safety at Work Act, food handling, lifting and moving.

This thematic approach was said to 'facilitate the incremental development of these core elements within each of the specialist courses'. Indicative of this were

the ten study days during the clinical practice unit were to be planned according to the 'individual needs of course participants'.

The integration of the themes and their application to specialist knowledge and practice was apparent in the course structure outlined in the curriculum document. Each course was divided into three units: a common core course, a bridging unit and a clinical practice unit.

Each theme of the common core course and the subsequent units had clearly stated aims, learning and practice outcomes.

There were 10 core unit aims relating to each of the themes. The third aim related specifically to health, stated broadly as 'To appreciate the concept of health'. Theoretical content included: concepts and definitions of health; Look after Yourself programmes and WHO Reports such as Targets for Health for All (1986) and nutritional literature such as the NACNE (1983) and COMA reports (DHSS, 1984). Apart from these official policy based documents there were two texts related specifically to health on the recommended reading list.

The bridging unit aim was to apply the 'knowledge of health' already gained to each of the four specialties and then expressed as specific learning outcomes in relation to both knowledge and practice.

In each of the four specialties the notion of health was applied and adapted to each setting and expressed in terms of students' learning outcomes and theoretical content. Their language reflected a commitment to the patient and family's wellbeing in the context of their lifestyles and future health. Safety aspects were contained in the unit of that name.

3) How was the course assessed and outcomes described (i.e. on what basis was the success of the curricula judged ?)

Assessment was divided into the summative assessment of theory and the summative assessment of practice.

Theory: Extended Research essay

Using the course themes the student was to identify an area of concern/interest within critical care as the topic of a 4,500 - 5,500 essay.

Patient Care Study based on a patient nursed during the student's clinical experience. The criteria only obliquely referred to health promotion/education in criterion (vi). The student was asked to 'outline the advice given to the patient prior to discharge'.

Clinical practice: All practice outcomes were expected to be achieved as part of summative assessment. As outlined above this included practice outcomes related to the health theme.

The certification of the achievement of outcomes was to be made by a 'first level' qualified nurse.

The Higher Award

The Higher Award had recently been developed and has the following core themes:

Research
Health
Professional Issues
Management
Teaching and Assessing
Interpersonal skills

A Specialist Module concludes the programme.

As with the ENB course philosophy discussed above the rationale to organising the programme in this way is to facilitate the development of knowledge in the core modules and apply them in the specialist end module.

The biggest change identified with the Higher Award was that students attend classes for three hours a week over a thirty week period. Release for brief periods from the clinical areas is easier to arrange compared to 55 days theory and 62 days practice required for the critical care post-basic courses. The new approach potentially detracted from student centred learning.

The Core Module on Health and Health Promotion aims to 'provide theoretical knowledge relating to health promotion as a professional activity'. Content is clear with a strong lifestyle, health measurement and community nursing orientation. However, political and economic issues are also indicated for inclusion.

Outcomes (objectives) include the demonstration by the student of awareness and understanding of the above.

Students were also expected to discuss their role in and develop a health promotion strategy for their clinical area.

Within the specialist Accident and Emergency module for example indicative content included 'The nurse as health educator' and outcomes required students to 'demonstrate an understanding of the physiology of trauma and its effect on health'. They were also expected to discuss their role within the Accident and Emergency department and apply the concept of health promotion in practice.

Teaching/learning strategies were listed as lectures, group and individual work.

Indicative reading included the texts referred to above but in addition Townsend P et al (1988) 'Inequalities in Health'; Tones BK et al (1990) 'Health Education: Effectiveness and Efficiency'; and Seedhouse's 'Health: the Foundations for Achievement'.

3) How was the course assessed and outcomes described (i.e. on what basis was the success of the curricula judged ?)

Formative: students were to review research on the determinants of health (1,000 words)

Summative: A 2,500 word assignment on the role of the nurse in promoting health.

4) How did the curriculum compare with WHO and UKCC publications (Both post-basic curricula) ?

Little explicit reference was made to publications by the UKCC although this was difficult to assess for the Higher Award as only extracts were available for review. Targets for Health for All, Government documents on nutrition and LAY programmes were identified within the theoretical content for the post-basic health theme. There was clear evidence however that the post-basic course curricula and particularly the Higher Award reflected the spirit of educational change towards a philosophy of health proposed by the WHO (1984).

2. THE LEARNING MILIEU

This section of the findings describes the 'learning milieu' within which the curricula described above were being implemented. Interviews, questionnaires and observation were used to generate these findings. The sample numbers in each data set is detailed in the 'Sample and Methods' section above. The issues surrounding the validity and reliability of the data are discussed in Chapter 3 on 'Methodology'.

The following aspects of the data were considered: Participants' perceptions of the process and outcomes of implementing a programme based on a philosophy of health and emergent hypotheses to be tested against their opinions ?

Identification of factors for and against the successful implementation of a philosophy of health by institution, specialities and educational levels.

Interpretations of a philosophy of health

In seeking to answer this question we had already defined the parameters in our research proposal and appendixed the WHO's discussion document on the concept and principles of health promotion as our yardstick (WHO 1984). A shortened version of the proposal was given to our local contacts in each centre who in turn made it available to their colleagues. We found however, that it was still necessary to give a personal explanation prior to data collection and to allow our participants to seek clarification from us. This was the case at South where prior to commencing a large group discussion with the teaching team at the beginning of the week, explanations were sought concerning the aims and objectives of the project.

During the discussion and subsequent interviews, the following information emerged concerning the teachers' and students' perceptions of a philosophy of health (as distinct from the written curriculum).

Most commonly, participants characterised a philosophy of health within nurse education as a shift from a disease to a health based curriculum associated with the introduction of the DipHE. As in other centres we sought to find out to what extent the shift towards a health based curriculum fitted in with the participants' own views of nursing and health care. For some the 1986 UKCC orientations had only served to confirm their own beliefs that nursing should be based on a philosophy of health. People who described themselves or their colleagues in this way tended to be midwives: *"It hasn't been such a change in direction for us.*

Our focus has always been on promoting health during pregnancy and child birth", health visitors (who were no longer on the teaching staff but had been seen as the prime movers for integrating a philosophy of health into the curriculum) and a small minority of general nurses who had begun as one participant put it *"looking round the corners"* beyond treatment and disease.

For the majority of trained nurses and teachers, (including the post-registration students) traditional nurse training had strongly channelled them into a disease orientated view of nursing and health care. Their educational programmes had led them to revise that view. For pre-registration teachers, the DipHE had served as the change agent.

The 1984 WHO definition of health was rarely mentioned by participants as playing a role in the shift from disease to health, whereas the 1992 Health of the Nation document was frequently identified as having an important effect in re-orientating nursing and health care. For one community nurse it was the 'pivotal change'. But most important for the majority of participants were the 'Look After Yourself' courses promoted by the Health Education Authority (HEA) and run by the local Health Education Unit which underpinned both teachers' and students' understanding of a philosophy of health. According to the College principal, six teachers had undergone LAY training so that they were in a position to pass on their knowledge to students and others.

The 'Look After Yourself' (LAY) programmes (dating from 1987) were characterised by a philosophy of health which advocated individual responsibility to 'make good any health deficits' by changing lifestyles to improve diet, encourage exercise, practice safe sex, regulate smoking and alcohol consumption and manage stress.

The Health Education Officer was responsible for the development of local LAY programmes at a community and institutional level . She had adapted the LAY strategy for use with the DipHE nursing students: *"As far as the students are concerned we are always very concerned about their (lack of) physical activity. It doesn't seem to happen after school and unless someone is quite well motivated ..... Our ethos behind it (promotion of exercise) was with back injuries, lifting and handling techniques, that sort of thing. I mean if you are supple enough and well oiled and exercised, hopefully the risk of those sort of repetitive strain injuries aren't going to happen. Therefore the students learnt about health from a wider perspective than just a clinical one. They also learnt how to relax to relieve the stress engendered from being seen as different and the pressure from the trained staff"*.

One of the tutors involved with the first group of DipHE students also described health *"from a wider perspective"*. Talking about the Common Foundation programme she said: *"We had a 2 day workshop in dealing with stress, to keep a healthy mind, spirit and body that went down very well. We also did a bit of aromatherapy, reflexology and relaxation"*

The students themselves (September 1991) spoke positively about the LAY programme describing it as *"really dynamic about diet etc. cholesterol, grieving, self awareness"*. They identified their health project as allowing them to go beyond 'no smoking, diet' etc. to understanding reasons why these behaviours occurred and to look at the biological, psychosocial and economic effects on health.

In addition, questionnaire responses and discussion, with more junior DipHE students (September 1992) confirmed a philosophy of health that incorporated a LAY approach of lifestyles, prevention, screening, education, special clinics and targeting vulnerable groups such as pregnant women and children.

Thus the students said they learnt about diet, smoking and exercise which they could apply to themselves. Health promotion in the wards was seen as a way of preventing readmissions; well-woman, menopause and other clinics as promoting a healthier environment. They also talked about stress management.

There was evidence of a socio-political and economic appreciation by a minority, including one student who identified financial guidance as an important component of health promotion. An awareness of health inequalities fits in with the view of the region as socially and physically deprived and LAY programmes as having a role in reducing the high incidence of cardiovascular disease.

A tutor who had recently taken a health education certificate hoped that an emphasis on health within the curriculum (like the course had for her) would give students wider knowledge and make them more politically aware of 'what was going on' in order to make changes.

In summary, the DipHE students' definition of a philosophy of health appeared to be based on a medical/educational model with some sense of being facilitative, including individual and group/population approaches through campaigns and education. To some extent individuals and community were seen as recipients rather than participants with a strong sense of the professional imparting the 'right' knowledge. The students' perspectives on a philosophy of

health therefore, appeared to be in keeping with what they were being taught.

Post-registration and basic students and teachers:

With reference to the LAY programme, one post-registration critical care teacher used the basic concepts to help students cope with patients going through traumas. During discussion, the post-basic students gave examples of putting LAY ideas into practice with patients and their families. They also demonstrated some understanding of environmental issues. One student who worked in critical care spoke of her involvement with the coronary care rehabilitation programme as an example of health promotion.

Another student from Intensive care spoke of the past when *"we used more like a medical model we treated the illness. It's no use if you then send the patient back to same risks and environment".*

Another student from the anaesthetics course who was a midwife said:

"In the past, even in midwifery, health promotion didn't feature broadly. You might give advice on various illnesses perhaps when it was too late. But I don't think you were talking overall to people as to how they could help themselves. I've changed from being reactive to being pro-active and consciously aware".

This midwife's view contrasted strongly with many midwives we interviewed both in South and elsewhere in that she did not believe that midwifery automatically incorporated health promotion.

One student from the operating department said:

"Health education is not only about the education of patients but also friends, family and colleagues. There should be a teaching programme where everybody contributes and learns because not everybody knows everything. You need to cascade the information throughout the department (theatres) It's ***a life philosophy*** *if you like".* (Researcher's emphasis).

The Accident and Emergency Post-basic student Group expressed the following perspectives:

"In A/E there isn't a patient that leaves the department you haven't advised on something or other. We have them for such a short period it's important you

give them the right advice."

The knowledge base related to disease and risk factors perceived as constantly changing, caused some concern for other students in the group.

"There's a lot of 'You should do this, you should do that, and then it changes. What was said last year, isn't this. So it's just what do you say ?"

The following example of the changing knowledge base was given:

"I read in Nursing Times that freeze dried coffee was associated with Alzheimer's disease. I told my brother and he went on to fresh coffee which I later found out was linked to heart disease. I don't know what he'll do now."

For another student: *"You get little snippets of the research, so unless you've actually looked at it should you comment ?"*

A health promotion lecturer in Centre A, brought up this point in relation to risk factors. She said that what was more important for her in teaching a philosophy of health based curriculum was to teach students about attitudes and approaches rather than facts.

The post-basic A and E students perceived of a wide range of health problems in the area beyond physical disease: unemployment, psychological ill health, heavy drinking, smoking, violence (currently identified as a number one public health issue in the US).

The importance of research based knowledge was consistently identified as an important component of nursing both in discussions, questionnaires and interviews but with few actual examples being supplied of what this knowledge base actually was.

As the field work progressed, it became apparent that a philosophy of health was seen not only as a matter of acquiring knowledge but also about a change in attitudes and behaviour. For example in post-basic education the shift in emphasis was reported by both teachers and students to be making the students who were also the practitioners, more questioning and re-examining traditionally held beliefs. As one student put it *"I trained in the old school where you didn't ask questions".*

One post-registration teacher from the operating department used a metaphor to

describe her change in attitudes away from a traditional nursing view towards a philosophy of health. Referring to this change as 'driving the car in the back seat' she said: *"Initially when I decided to be a nurse I thought you did everything for the patient. But I don't think that now. It's like driving the car in the back seat. You hope to enable those people to support them and look after them in caring for their families".*

DipHE students found projects, such as neighbourhood profile were good for building up team work skills (September 1992).

Both pre- and post- registration students described changes in their own behaviour related to smoking, diet, exercise. The health based curriculum was said to 'build confidence', 'make them 'think', 'be more aware' and 'help patients to make informed choices'.

As mentioned above the students had a strong sense of the 'professional' imparting the 'right knowledge'. On some occasions this could give rise to dilemmas around the 'professional' practising what they preached. This issue arose during discussion with DipHE students as follows:

The question arose as to whether a nurse could advise a patient if she was not practising a healthy lifestyle herself. For example, could the over weight nurse offer information on diet to a person who had just had a heart attack ? Some students felt that they could do so as long as they offered advice rather than 'telling' patients what to do.

One disadvantage of the LAY philosophy of health was the potential for it to be interpreted as 'prescriptive'.

The tendency to see health in terms of telling people to refrain from harmful activities was frequently manifest (as in other centres) by the much quoted example of the appropriateness of giving advice to stop smoking, especially if the patient was elderly and had lung cancer. As one student put it the patient *"might as well be happy".*

There were a number of allied concepts and skills frequently associated with a philosophy of health. Many of them incorporated concepts and skills 'traditionally' associated with definitions of nursing such as holism, communication, caring and community care.

For example Branch students (September 1991) during discussion proclaimed:

"health education and health promotion is the caring role' and 'a philosophy of health puts the emphasis on holism and the whole person".

Similarly, for a post-registration student: *"It (a philosophy of health) is like taking the patient and family holistically".*

Branch students pointed out how being supernumerary on the wards meant they *"had a lot more time to sit down and talk and communicate with patients which is a vast majority of the caring role".*

Thus *"a big part of a philosophy of health was to take time, interact and communicate with patients in a way that's beneficial to them".*

Students in the CFP (September 1992) during discussion (and confirmed in their questionnaires) declared communication to be the 'top skill' required for health promotion.

For a post-registration student as an outcome of her studies *"communication has increased for me. I explain more and encourage patients to ask questions".*

But to achieve a philosophy of health was not easy as one post-registration teacher pointed out: *"To actually help with the awareness of health promotion in areas that are critically very busy you have to dig your heels in and say this is a priority, because the immediacy of the situation often decides what happens. The need to distinguish between the immediate and other needs. As nurses we often focus too narrowly on what a patient's needs are to the detriment of their emotional health... We've got to care holistically: not focus on clinical rules".*

The community (in peoples' own homes and General Practitioners' surgeries) was identified by branch students as being an easier setting in which to implement a philosophy of health operationalised as 'giving health education'.

The teachers we talked to believed that looking at health first before disease was the 'right' approach. Their degree of commitment varied depending on how they viewed a philosophy of health as part of nursing. When the DipHE started, the majority of teachers were primarily involved in keeping the traditional curriculum running which they saw as 'very different'. One tutor felt that subsequent involvement with the DipHE had brought commitment to and understanding of its philosophy. But for another tutor it was still a question of finding the right balance between health and *"looking after sick people".*

" My initial feeling about Project 2000 was the emphasis is too much on health and that's difficult to change unless you get involved. And because I've been involved with this group I have found it really interesting and I am slowly beginning to change my ideas".

and

" I think they do need to know more about health than they did because before we were very disease orientated. It's necessary to know what is normal before you can deal with ill-health but you can't ever get away from the fact that nurses come to nurse sick people".

and

"We don't know if it's going to work although I'm more and more convinced that it will. But you have to maintain confidence in the principles.".

The practice nurse co-ordinator talking about DipHE students said: *"From what I see here they look at health before illness and that's the right concept to take on board. They are very community orientated because they do things like neighbourhood profiles, so they know what the patches are like".*

At the other end of the spectrum, there remained some teachers who were uneasy about the changes because they still believed the nurses' primary function was to look after sick people rather than promote health.

Some were still ambivalent, reserving judgment or others who were 'sceptical' of the approach. One tutor reported: *"There are members of staff who teach about health and don't believe in it".*

Overall students welcomed the introduction of a philosophy of health. During discussion the branch students (September 1991) gave a variety of positive comments: For one student the approach was *"really worthwhile".* Another student *"enjoyed all the placements"* whilst yet another said:

"The beginning (Common Foundation Programme) was health but I can now see where it fits in especially out on the district where the district nurse's role is as a health educator".

The students at the end of their Common Foundation Programme during discussion and in questionnaire responses, gave the following perspectives : In

general, they were positively disposed to the shift to promote health although they thought the subject matter from the CFP could have been condensed to six months. They also wanted more practical experience of applying health promotion to practice.

A post-basic student whilst supporting a philosophy of health was all too aware of the clinical realities which prevented its implementation:

"I agree with it but it's going to take a long time to see the effects of introducing a philosophy of health. It's because the priorities and resources (within the health service) are still geared towards acute illness".

Preparation for a Philosophy of Health within the Curriculum

Look After Yourself (LAY) programmes appeared to be one way in which teachers were prepared for a shift towards a philosophy of health within the curriculum. Only one pre-registration teacher (other than the HPO) had specialist qualifications in health education.

Teachers told us they had needed more preparation time including improved library resources, to question their own values before beginning teaching a health based curriculum.

"You have to be sure of yourself as a tutor. We don't know if it's going to work although I'm more and more convinced that it will. But you have to maintain confidence in the principles".

They would have welcomed contact with a nearby DipHE Project 2000 demonstration site. The reasons for the lack of contact were unclear but some teachers believed the other college might have been reluctant to share ideas.

Although the shift in emphasis from disease to health was described as 'slow' the preparation and introduction of the new curriculum had taken place within a nine week period (June to September 1991). A steering group was formed and consisted of people who were involved with the first DipHE students. Two health visitors on the College staff (since left) played an important role. In North the group included a mental health tutor.

One tutor described the group process in the following way: *"We had some fraught meetings in the steering group - we never parted without making up but we had some 'well I don't think it should be like that' and you had to stop and*

be flexible about what people could do and come to some compromise".

The general feeling from the group discussion with teachers was that preparation for the DipHE was inadequate saying: *"There were study days but they weren't much use if you weren't very involved. It was meaningless".*

When the DipHE started, the majority of teachers were primarily involved in keeping the traditional curriculum running which they saw as 'very different'.

One tutor felt that subsequent involvement with the DipHE had brought commitment to and understanding of its philosophy. Another felt she had learnt about a philosophy of health *"through doing"* but added *"there's got to be an easier way".*

Because of the speed with which the DipHE was implemented the tutors generally felt unable to prepare for the changes. One participant suggested that maybe a counsellor could have been appointed to offer the support many felt was necessary to prevent the subsequent isolation, stress and sickness some of them experienced.

Tutors reported little opportunity to prepare clinical staff for the changes. They were surprised at how different the clinical staff found the mentoring of DipHE students from their traditional counterparts. A number of roadshows were mounted for the staff in addition to visits to clinical areas by tutors where students had not been allocated for some time.

Some DipHE students commented in their questionnaires that the trained staff viewed them negatively. The HPO described the importance of *"getting the clinical staff up to a standard"* for the shift towards a philosophy of health:

"I want to run health promotion courses on the wards for the health facilitators, for the nurse facilitators. Really everybody that's going to be a facilitator for the Project 2000 needs to be up to the same standard as the people who are actually going to come onto their wards in knowledge awareness and everything as far as health promotion is concerned".

The post-basic students said they found it hard with their new found knowledge and attitudes to return to their own areas where there was still resistance to change. It was reported that project proposals developed during their courses soon got shelved. One student had been keen to continue her study of post-traumatic shock syndrome on return to her clinical area but had found little

interest from her colleagues.

The practice nurse co-ordinator said that in the community in order for the practice nurses to act as facilitators they were expected to have ENB course 998 but there were still insufficient nurses prepared in this way. This situation was improving because many of the practice nurses were studying for a health studies diploma (which included a health promotion module) at a neighbouring college of higher education. The course was run by two health visitor lecturers. The co-ordinator who also taught on the course was confident the diplomates would be well prepared to facilitate DipHE students. We met a charge nurse who was studying for the diploma. He worked on an acute medical ward where DipHE students were allocated and claimed some familiarity with their approach. We inferred from our discussions with the practice nurse co-ordinator and the charge nurse that the Health Studies Diploma played an important role in promoting a philosophy of health to a wide range of practitioners in the local area.

On reviewing the preparation for a philosophy of health in the post-registration courses, it appeared from the curriculum documents that clinical staff were well represented on the planning groups (seven clinical staff to four educational staff). Each specialist course had a sub group comprising staff from the relevant clinical specialities committed to integrating theory and practice in each module, including health promotion.

Operationalisation of health within the curriculum

As shown by our analysis of the instructional system (see above) the curriculum documents reflected a commitment, shift and integration towards a philosophy of health. Our documentary analysis was confirmed by a number of findings on the learning milieu.

As in other centres we tested the hypothesis that the role of mental health and learning disabilities played an important role in the operationalisation of health in the curriculum.

Although we did not conduct individual interviews with the Mental health and Learning Disabilities tutors, we found evidence to support this trend. For example, in a teaching session on assessing children with special needs an holistic approach to assessment was observed. Of particular interest was the discussion of the sexual needs of an adolescent with learning disabilities.

Community placements were seen as important ways of operationalising health within the curriculum. Branch students said: *"You get to see more and understand more in the community. The Health Promotion Unit organise quite a lot of self awareness days such as 'No smoking'".*

Teachers said that students would have community placements throughout their branch programmes. The practice nurse coordinator felt students required *"greater community experience during the Common Foundation Programme working with district nurses, health visitors and practice nurses".*

This view was confirmed by another tutor:

"The community placements should be longer to give the community more emphasis. At the moment, students do two days with the Health Visitors. They have time in residential homes and nursery placements. We don't have much liaison with the community staff for feedback. The placements are difficult to organise because times are tight in the community".

Project work was an important method for operationalising health within the curriculum: *"There was a lot of emphasis on the course on the type of projects we did. People had a lot of projects related to health and that was interesting and you could use it in your work". (Post-registration student)*

Students gave the following examples of projects they had undertaken as relevant to their clinical areas: Immunisation; Post-traumatic stress syndrome in Intensive Therapy Unit patients (referred to above); Post-coronary Rehabilitation; Pre-operative Visiting by theatre staff.

We used the observation of teaching methods as an indicator of whether a philosophy of health was being operationalised within the curriculum. The two teaching sessions we observed used interactive teaching methods. Group work following more formal lectures appeared to be a popular approach. The relationships between students and teachers were relaxed. The rooms were organised to allow the students to work in groups around clusters of tables rather than rows of desks. In one session, students only three months into their training, appeared at ease in front of their peers, were verbally articulate and presented materials confidently. They handled Over Head Projectors and transparencies with ease. Although our classroom observations were limited they suggested an adult learning approach consonant with a philosophy of health was being adopted and that the students felt valued and empowered.

The 'hidden curriculum': How healthy is the learning and working environment ?

Generally in reply to this question students and staff felt that the working environment was not healthy because of the stress associated with health service and educational changes.

There was said to be an effective occupational health department in operation at the hospital. No smoking policies had been implemented and were frequently quoted as an example of promoting health in the working environment.

A student pointed out that 'having a home to live in' was important for health. She was referring to the fact that many students were having to leave the nurses' homes in South for more distant quarters because of a redevelopment by a well known building contractor. The nurses' homes were to be converted for sale as luxury flats.

The process of integration

Teachers raised the following dilemma around the issue of being a specialist versus a generalist teacher and its implications for integration. They pointed out that being a specialist potentially militated against integration. On the other hand, being a generalist undermined confidence in subjects with which they were least familiar. Two teachers mentioned their previous experience of teaching specialties on the modular plan of training and how much they had enjoyed that approach.

The teachers we spoke to appeared to have become generalists, basing the curriculum on seven themes of learning as described in the curriculum document and outlined above in the instructional system.

Allocation of subjects and the limitations of and potential for integration was described in the following way:

"Basically as a team we'd look at the timetable and decide who's going to do what. If for example we're doing a whole morning on health we may break it up into three bits. Each one of us does one of those bits but its where the overlap comes. You need to liaise quite closely and its not always possible even working on the same team if they have other commitments'.

The student questionnaires (see Form A, Appendix ix) gave the following

perspective on the integration of health with other subjects into the health based curriculum.

The responses to question 8 on the part played by biology, sociology, politics, psychology, nursing in a philosophy of health are used to describe their perspectives.

Twenty-eight questionnaires were distributed, completed and returned. The process of data analysis is described in Chapter 3. On the basis of their responses, the research team allocated the students to one of two groups. Fifty per cent of the students (fourteen) said they regarded each discipline as an integral part of health and so therefore declined to comment on each discipline separately. Six of the fourteen specifically described the disciplines as part of an holistic approach to health.

The remaining fifty per cent (fourteen students) identified the particular contribution of each discipline. The number of students who commented on each discipline follows: Sociology (8 students); Psychology (5 students); Nursing as health promotion (5 students); Nursing (4 students); Politics, Biology (3 students each). We inferred from the students' responses that the theoretical underpinning of the disciplines appeared very applied. For example, sociology was said to be more like social policy, whilst psychology was described as giving insights into 'mental health'. Other students described sociology in terms of social class, inequalities, geographical differences. Politics was seen as government reforms, ethics, nursing politics, history of nursing and the NHS. One student wanted to see the continuation of the LAY programme throughout the three year course.

The inferences drawn from these findings suggest two interpretations. The first interpretation is that the respondents held a highly integrated approach to health within the curriculum. The alternative interpretation suggests their responses indicate a broad, non-specialist knowledge base where notions of health, health promotion and education overlap and merge with notions of nursing and caring. In order to integrate a philosophy of health into the students' practice, the Health Promotion Officer had appointed DipHE students to be responsible for particular health topics such as AIDS, smoking, food handling. The students had agreed to be on call for national events and health promotion activities. This arrangement indicated a positive relationship between the health promotion officer and the students and confidence in their ability and motivation.

During discussion, DipHE students perceived health promotion as an integrated part of the nurses' role, particularly in the community and enhanced by

teamwork. Teachers reported that students had strong allies in health visitors and learning disabilities managers. The latter regarded the students as having a broader view of care and more awareness of clients' needs than traditional students. As noted during interview with clinical staff and reported by students and teachers during interview, discussion and questionnaires, general nurses were less comfortable with the DipHE changes.

CONCLUSIONS

The move towards integrating a philosophy of health into the curricula in Centre D College of Health was perceived to be relatively successful. Students appeared empowered and positive in both pre and post-registration courses about the shift. The role of the nurse as a health promoter was seen as important and health promotion a part of nursing.

Centre D's South site is the only institution we studied where generalist teachers have continued to teach DipHE students. It appears they have more successfully progressed towards integration of a philosophy of health than elsewhere. However there are significantly smaller student numbers in this centre which may facilitate integration.

One difficulty identified was that students lacked role models because the current health service is designed to meet illness needs. It was suggested that with increasing numbers of clinical staff undertaking post-registration education based on a philosophy of health they would potentially act as role models for the DipHE students.

However, despite the motivation and ability to do so, students in post-registration courses still found integrating health promotion into their clinical practice, difficult because of the acuity and pressure of the patient workload.

As one post-registration student put it: *"the emphasis is still on illness (in the clinical environment) and that's the way our jobs are structured unfortunately".*

Other post-registration students also gave examples of how they had good ideas during their courses and completed projects on a variety of topics. But on return to the busy clinical areas they had been unable to implement their ideas.

There was a disempowering feeling of stress in this centre and one post-registration student gave a representative view when she said:

"Health promotion can only go so far to alleviating stress from the so many changes: two hospitals amalgamating, fear of redundancies, changes in nursing structure. Rumour is rife which is also very stressful".

It was also apparent to both students and staff that the post-registration courses had become finance rather than student driven.

Everybody we spoke to was very aware of the new market arrangements within health care. For one community teacher and practitioner this was particularly apparent with the move to fundholding general practitioners. She also saw the move towards a philosophy of health as one of many changes but the pivotal one towards which 'The Health of the Nation' was geared.

Overall, the Centre D College of Health, measures up favourably with the 1984 WHO policy document. The programmes are in touch with local communities and the nurses are more likely than in other centres we studied, to originate from the community they serve. Student placements and theory include political and community development approaches.

Nurses' distinct role in health promotion was identified by the WHO as education and health advocacy and it appears that the students are being given the skills but have difficulties applying them to practice. One dilemma inherent in promoting a philosophy of health raised in the WHO document is the potential for 'healthism' and prescriptions for health. Look After Yourself programmes, such as those taught in Centre D, may reflect this dilemma. During discussions students expressed concern about having the 'right' knowledge in order to be able to tell patients and clients 'what to do' to promote their health. But they also learnt assertiveness skills to enable them to widen their concepts of health promotion and develop networking strategies in voluntary and statutory agencies.

Meyer's (1986, 1988) criteria for assessing integration are met. All the programmes we studied in Centre D College of Health had explicit health promotion sessions. In terms of the pre-registration DipHE programmes, the largest concentration and emphasis is in the Common Foundation Programme rather than in the Branches. However, whether there is a need to give more

emphasis on a philosophy of health with opportunities for consolidation later in the programme will become apparent when the first diplomates graduate in September 1994.

CHAPTER 9

COMMUNITY NURSING COURSES

SCHOOL OF HEALTH STUDIES 'NEW' UNIVERSITY

The research team consulted two members of the School of Health Studies at the 'New' University in a large city. We interviewed the Head of Department and a health visitor lecturer to gain insights into the health visitor perspective in integrating health promotion and health education in educational courses.

The university provides both full and part-time courses on a modular scheme and their experience of both modular teaching and community nursing courses might be helpful for future nursing education initiatives.

Both district nursing students and health visitor students take a Diploma in Professional Studies which integrates with a BSc in Applied Social Science. There is shared learning with non-nurse BSc undergraduates. Currently the college offers about 30 full time places and 50 part-time places for Health Studies students. There are similar numbers of students on parallel courses: social research; politics; policy studies; information studies; social work and cultural studies which are all key components of the BSc.

The 'New' University has linked up with a neighbouring College of Health Studies, which has become an associated institute. This College is an amalgamation of five former Colleges of Nursing. Students studying for the Diploma in Higher Education (DipHE) from the College of Health Studies attend the University on two days per week.

All community nursing students take the following core modules: social issues for health practitioners; social psychology related to community health practice; communications - counselling and group work; managing change; research awareness; health promotion and health education and perspectives of aging.

Those progressing to a district nurse qualification take separate modules which emphasise theories of nursing and clinical aspects of care. The health visitor students take modules on child development and health visitor practice.

The health promotion and health education module is comprehensive and although the course is modularised, considerable thought has been given to integration.

The Head of Department commented:

"Although we have got a module called health promotion, it isn't the only place where health promotion teaching goes on. It's where we are calling it health promotion at the moment but we have cores, one called Health and Illness in Society, one called Health Care and Health Policy at Level 2 - all health visitors and district nurses take those. We have one on older people for example, and in a sense I would argue those are all health promotion, although they don't have health promotion in the title. They are getting health promotion across a much broader dimension than that".

The main principles which underpin health promotion in this course are advocacy, enablement and mediation. Emphasis on the newer paradigms were also apparent in the course structure and the reading lists, such as political influences, skills workshops on communication and HIV project initiatives. This combination produced a course from which students emerge with a wide range of skills and perspectives and a deep knowledge base.

Important issues and helpful insights arose from our discussions. It appeared health visitors were in favour of the change in philosophy for DipHE (Project 2000) students. The Head of Department explained:

"I think the changing patterns of health and disease, demographic change, its the only way that nurses can go (towards a shift in philosophy towards health). Its absolutely got to happen.. but I think it depends how you view health promotion in a sense because certainly what I think very much is that health promotion isn't about telling people what to do, it isn't necessarily even just about educating patients. I think it requires the next stage, if you like, in health promotion for all nurses and for Project 2000 nurses as much as anybody else, is a move towards seeing nursing as one part of a larger spectrum of health. So how do you relate to a social worker in community care ? Or how do you relate to the local planning department, who might be looking after pavements and street lighting and you're involved with old people's feet ? And those things are all part of life's rich spectrum, that I think is very important that nurses see where they fit into that whole pattern of health promotion - I think around public health and community care - is just becoming much more to the fore. I think if we don't bring nurses right from stage one into that whole framework then we are doing them, and we are certainly doing patient care and health care, a huge disservice".

Generally however health visitors had not been consulted nor their expertise

accessed to the full in developing the DipHE curricula.

"No, I don't think they have (been consulted). I think health visitors have had a lot more to offer. I think if they had been involved in the process... That's sometimes their own fault too. They for various reasons, have perhaps been a little closed to some of that. But I think they could have been much more tapped and district nurses too, the school nurses and the community psychiatric nurses and so on. I think with health visitors, in terms of some of their health promotion roles, there are some excellent projects going on and different ways of working in Health Visiting. Neighbourhood nursing that has developed over the last 6 or 7 years that I think could have been used much more, I think could have been used much more than they have been. I think it's a little bit in danger of almost translating institutional care into the community and I find that quite worrying when it could be much more open. It's maybe phases and steps on the way but there's much more that ***could*** *be tapped into than* ***is*** *being tapped into" (Researcher's emphasis).*

The advantage of running courses in a higher education context rather than in a college of nursing was stressed, as in the former setting there is a much wider range of influences and expertise available. For example, in the Health Studies department, there are lecturers with a strong commitment to public health, community health and community care and lecturers who have experience of local authority and the voluntary sector. Consequently the students are exposed to a variety of perspectives on health and health promotion as well as the traditional medical and educational models.

Another issue the Head of Department raised was that of clinical placements. Feedback from the community managers and community practice teachers indicated the tremendous strain on and overload of practitioners in continually having students. Doubt was also expressed about the value of some of the placements for the students.

"How much they get out of what they see is debatable. We've all done it, there is a sort of check lists mentality, get them all round the East End - what the quality of their contact with people is, needs to be looked at. Project 2000 courses are just getting going - I'm sure lots of them are adapting all the time and having to change and say whether those placements were worthwhile for students.

" I tend to think we could do a lot more experiential learning linked up with some of the placements that might make it more useful to some of the Project

2000 students. I know they have got to dirty their hands and really see things but I sometimes think they might be best to have some videos, a shorter visit, some real debate and discussion about what that particular place in the community means rather than going on mad goose chases and spending a couple of hours somewhere. I think we really do need to think more about it. I've got this thing about, everybody has got to be in there and one can really have good arguments as why that is the case. Practically, it's terribly difficult and I'm not sure in terms of quality that it's the best. When you think about how people teach around mental health. The ethics of actually going into somewhere like a learning disabilities placement. There are so many things that you can do in a college setting or in a seminar room of a mental residential care setting, it doesn't matter where. There are so many things that you can do, that don't require them (the students) to be face to face with people all the time, that are maybe disturbing the people. It's not that useful in many ways.

" I would really like to see a shift in some of that. Medical students are already doing it in places (mentions the neighbouring health authority). When hospital beds close, where do you train the medical students ? Their education changes. The whole community is going to become just one hospital institution if we are not careful".

These doubts about the quality and usefulness of the placements were echoed in all the other Centres. Students themselves often failed to see the significance of their visits and felt uncomfortable being with clients for long periods of time with 'nothing to do'. The placements always emphasised to the students their lack of knowledge base and skills, as they often felt they should be pouring forth advice and support on ways of enhancing health and modifying behaviour.

Much more could be made of the idea expressed here of focusing on a short contact time and building on the interaction with workshops and seminars.

Another interesting point was mentioned by the Head of Department.

"I sometimes wonder if Project 2000 isn't the wrong way round - people have got such a thing about community coming in from the beginning which is of course absolutely right and proper. Students don't want it if they're not listening. What you find when you teach 3rd year nurses and certainly anyone beyond graduation point in nursing is that their interest in the community and in health promotion and prevention issues - a large percentage are aching to know about it. They've certainly reached the conclusion 'why are these people here ?' ... 'What could we be doing in other ways ?' In a way what we've done

with Project 2000 is frontload it with community for very understandable reasons, that it's really got to permeate the curriculum, and perhaps we ought to be thinking about much more the other end, where they become more mature, they know the system more and their interest level would be up. That would be another way of doing it. It's very interesting too what is going on, there are some very exciting things going on."

Again the point is emphasised about the importance of a philosophy of health and health promotion being part of the more senior nurse's curriculum and the integration of these concepts throughout the 3 year DipHE course being vital.

The observation that qualified more senior nurses are motivated towards health promotion has arisen elsewhere. Health promotion lecturers in other centres emphasised how they enjoyed teaching qualified experienced nurses, in preference to novices, who sometimes are thinking only about uniforms, wards and machines that go beep.

One of our consultations early in the project was with a health promotion adviser who worked for the Welsh health promotion agency. She concurred with the view that health teaching should not only occur in the Common Foundation Programme but also and more importantly, it should occur later in the course.

Two other important issues arose, which may be helpful to future initiatives in nursing education. One was the issue of PREPP and the other was about the Credit Accumulation Transfer System (CATS). If nursing courses are to be modularised then these issues will become increasingly important.

Elsewhere lecturers had felt that PREPP at Level 3 was too high for most nurses. In this discussion, the argument in favour of a Level 3 entry was strongly stated.

"Absolutely..... I think PREPP should be at Level 3. I think nurses are in danger of being short changed on the academic side. If we are not careful we are going to end up with nursing courses that are seen as second class to regular academic degrees and that's the last thing that nursing wants. That worried me quite a lot really. Bringing in people at Level 3, of course they have the most incredible skills that most people coming in here don't have. You have to find a way of not undervaluing those but while saying 'can you really deal with some of the academic work?' They are different, some of the health visitors and district nurses are the brightest students, brightest in inverted

commas, that we have coming in and doing the undergraduate programme. But it is quite clear when some of them come in at Level 3 that they haven't got the academic skills around developing and analysing arguments for example. They can produce excellent work but it's in a very superficial sort of level and if you just take them back on some of those things they missed out on, you're going to fast forward them because they are smart. They often don't have the background, whether it's in science, or social science or whatever it is and I think we are in quite a lot of danger of short changing them - if we bung them in and they are not quite ready to be put in there and its not undermining them at all, it really isn't. I feel very strongly about that". (Head of Department)

The Head of the Department discussed the CATS system at the 'New' University which appears to have had considerable effort devoted to it and is working well.

The majority of experienced nurses pursuing higher education, whether on structured courses or with PREPP will face the problems mentioned in the previous quote. Thus they will have considerable knowledge, experience and intelligence but will probably lack a solid academic base. The implications for post registration education are that different approaches may need to be taken for the DipHE diplomates who have an academic background and others who do not.

In response to a question about DipHE diplomates wanting to take the Diploma in Professional Studies, the Head of Department responded:

"We have that in mind the whole time. The current diploma in professional studies is quite new, it's only the second year of running. So it was set up very much with the idea that we would be getting a whole variety of students including Project 2000. What we would really like to do and what the ENB makes it very difficult for us to do, although we have it written into our validation, is that we have the sort of programme where students can come in if they are Project 2000 diplomates, they could give us their transcripts, we could very carefully see what they have done and they could have on offer some other modules that would benefit them rather more. It's actually very difficult to do that, we do that all the time with our regulars, we get loads of students all the time. We very carefully set up a credit transfer system, a CATS system. They would come along and say I've done this and this and they could get their own programme going. Now Project 2000 students should be able to do that, there's no reason why they can't. In fact, although the ENB are very much into

credit accumulation and transfer, we still find it quite difficult to enable the students to do that.

" In health visiting, they won't take our credit accumulation and transfer process as being appropriate enough, they have to apply and it's months before they come on a course, on a modified course as they call it. We just don't operate like that, we've got the system, we've got the set up, we would be very happy to share it and say to the ENB, 'look this is what we've done, this is what we are proposing'. The students could do it themselves, we've got student programme forms and so on. It's really quite difficult to do that - in theory, we have got a perfect system, in practice it's quite difficult and its the bureaucracy that prevents it.

" In future, you do need a quite different sort of course but you can't run 2 courses, you've got to be able to have that 'well, where are you from, what is your background, what have you done, what do you need on this health visiting course?' There is a core in health visiting or a core in district nursing and whatever you've done, we are saying, even though you are going out, you've done community work, this is the advanced practitioner, the specialist practitioner and there is a certain amount that you have absolutely got to do. But around that they could have a smashing programme so it's there set up once you are into modularity and you are linking in with other areas - you might want to do science, they might have developed their Project 2000, they might want to do something around nutrition, we have got a dietetics course. Or it might be something else in the science programme, there is no reason at all why they can't have that as part of their programme too. We do it with our undergraduate students - there is a number of them that go and do social nutrition. But Project 2000 students, if they've got the right sort of background, the pre-requisites, could do science.

" So the situation exists for a lot of inter-change. That also brings its problems because, like in all modularity systems, you've got to hang on to the notion of cohorts and cores and all of that. Essentially though there is a lot of flexibility there".

Conclusions

The main issues which arose from these discussions include:

* A positive response from community nurses towards a philosophy of

health in all nursing courses;

* Regret that their experience and knowledge had not been sought fully to help promote the radical shifts taking place;

* Courses exist which are immersed in a philosophy of health and health promotion (in this college, for example) for community nurses which **are** integrated and which embrace many varied perspectives in line with national and international policy;

* Indication that the majority of community nursing courses are similar to the one at this University;

* A successfully functioning CATS system;

* Reports of general dissatisfaction from local community nurses about the usefulness of clinical placements for the Diploma in Higher Education students and some good suggestions about modifications;

* The current initiatives in post-registration education proposals seem to have been developed with Diploma in Higher Education diplomates in mind, the background and study skills of traditional nurses and midwives might need a different approach and the implications of needing two approaches might prove controversial;

* Health promotion is a vitally important component of nursing which needs to be addressed by experienced, senior nurses, in order for the Diploma in Higher Education system to be successful.

CHAPTER 10

SUMMARY OF KEY FINDINGS

Below follows a summary of our key findings derived from our case studies and one consultancy.

Health Promotion's Body of Knowledge

Broad interpretations of a philosophy of health were found including socio-political models and a community influence. However, the overwhelming influences were from the traditional paradigms characterised by Macleod Clark and colleagues (1992) as concerning the physical health and disease prevention of individuals in a 'top-down' way. 'The more modern and enlightened approaches' characterised by the same authors as emphasising the psycho-social aspects of health, equity, 'empowerment and multi-sectoral planning', were less in evidence.

There was an implicit assumption from written curricula and respondents that absence of disease or units on normal functioning was equal to health. This demonstrates a limited understanding of the body of knowledge of health and health promotion.

Many assignments and learning outcomes were orientated towards the role of health promotion in nursing or midwifery, with no evidence in the curricula of any theory on which to base their practice. Reading lists on the topic were limited.

Even though the predominant view amongst midwives was that they had always been health promoters, the midwifery curriculum we examined at one centre, was found to be predominantly concerned with medical model approaches within a biological science framework.

A midwife on a post-registration course at another centre did not support the majority view that health promotion was part of midwifery practice as the following quotation illustrates. She said:

"In the past even in midwifery, health promotion didn't feature broadly. You might give advice on various illnesses perhaps when it was too late. But I don't think you were talking overall to people as to how they could help themselves. I've changed from being reactive to being pro-active and consciously aware"

Thus as this student infers, the nurse or midwife does not automatically become a health promoter just because the practitioner deals with a normal event. Numerous skills and abilities are required and these need to be addressed theoretically and clinically.

In one centre (with a high regional incidence of coronary artery disease) the Look After Yourself courses promoted by the Health Education authority and run by the local HE unit underpinned both teachers' and students' understanding of a philosophy of health. Six pre- and post- registration teachers had undergone LAY training and so were seen as being in a position to pass on their knowledge to students and others.

The LAY programmes dating from 1987 were characterised by a philosophy of health which advocated individual responsibility to 'make good any health deficits' by changing lifestyles to improve diet, encourage exercise, practise safe sex, regulate smoking and alcohol consumption and manage stress.

All case study centres had made significant progress towards meeting the UKCC (1986) recommendations. Dramatic changes have occurred since the Health Education Council survey in 1980 found that Schools of Nursing had no working definition of health education or health promotion. Participants in the four centres all characterised a philosophy of health in the following manner: - health education is seen as a shift from a disease to a health based curriculum associated with the introduction of the Diploma in Higher Education (DipHE). Curricula had been 'embedded in health' to varying degrees.

Although we used the 1984 WHO discussion document on health promotion as our yard stick it was not mentioned as a guiding philosophy. The original WHO definition of health however was cited (WHO 1965). It is in this earlier definition, that the ubiquitous phrase - 'absence of disease' was first mentioned.

The British government's response to the WHO's call for health for all by the year 2000, the Health of the Nation White Paper (1992) was frequently mentioned as being influential despite it post-dating the curricula shift to a philosophy of health.

The Community Nursing Courses which we heard about during our consultancy at Centre E, were the only curricula to emphasise the newer paradigms of health promotion. The principles of advocacy, enablement, mediation and political influences, communication workshops and HIV initiatives were apparent in the course structure and reading lists.

Health first ?

The majority of respondents agreed that putting health first in the curriculum was the most sensible course of action and supported all initiatives to do so.

Degrees of lecturers' commitment to the philosophy varied. There were those who had always felt health promotion to be an integral part of nursing and been committed to curricula embedded in health. This cohort were either nursing graduates or had taken postgraduate Masters or diploma courses in health promotion. Another group of teachers were those who had been persuaded that this was the best path to tread for the future of the profession. Some of them planned to take Master's programmes in the future. They had generally learnt their health promotion on the job or from their own intellectual curiosity. Even without formal qualifications in the topic they showed some degree of insight and knowledge.

Others were going along with the tide and were not really convinced that nursing should be embedded in health. They might be teaching the topic, although not really believing in its value. A minority were still committed to a disease model of learning for nurses and it was still generally considered that lecturers who had been teaching a disease based curriculum could automatically switch to teaching one orientated to health. Some lecturers currently taking degrees and diplomas in Nursing, reported that health promotion was neglected in these courses.

Overall however, Ward and Faulkner's findings in 1983 indicating no difference in health education knowledge between teachers and students, appeared no longer to be the case.

One critical care post-registration student whilst agreeing with the shift to health put the innovation in perspective when she said: *"It's going to take a long time to see the effects. It's because 'out there' (meaning the clinical areas) the priorities and resources are still geared towards treating acute illness".*

Dominance of Medical Models of Health Promotion

The dominance of the medical model of health promotion was noticeable in the four case study centres. Our main informant at Centre E where we undertook a consultancy to look at District Nursing and Health Visiting Courses, did not ascribe to this view.

We found in the other centres, the students' views on promoting health were generally unclear.

When asked about their understanding of health promotion, we obtained broad definitions, with a few students incorporating social and political models. Overwhelmingly descriptions of traditional paradigm approaches emerged, such as concerns with physical health, lifestylism and an individual top-down approach.

For example:

"Health education ... is about informing people of how best to prevent diseases/conditions before they happen and how to cope with existing diseases/problems. Health promotion is where active steps are taken such as passing legislation to promote health" (Centre C, second year student).

Or the promotion of health was seen as:

"Providing clients/general public with information (on healthy living) and knowledge so that they can make an informed decision about their lifestyle such as stopping smoking; safe sunbathing or eating low fat diets" (Centre A, first year student)

Occasionally students gave examples of stress-management and relaxation, but only in relation to their own strategies for promoting health rather than for patients and clients.

Giving information and leaflets featured strongly. For example student midwives understood health promotion and education as providing leaflets and information booklets on topics such as preventing smoking, sexually transmitted diseases and violence.

When asked for examples of health promotion or health education in clinical practice, overwhelmingly medical and educational model examples were used. One group of post-registration students during focus discussions described health promotion as immunisation; advice on breastfeeding; family planning and discharge checks. They gave no examples of planning and negotiating health promotion strategies with patients and clients.

Although 'communication' was declared as the top skill required for health promotion, concepts such as advocacy, collaboration, mediation, negotiation were rarely mentioned.

Integration towards a Philosophy of Health

Many aspects of a philosophy of health and health promotion are present in all the written curricula of the four case studies, but in practice they have not been integrated in a way that is apparent to most students or in ways they are able to understand or apply.

An example occurred with the curriculum for care of people with HIV/AIDS. The students were exposed to a creative and broad interpretation of health promotion ranging from social, political and media aspects of health promotion to nursing strategies and complementary therapies for maintaining a strong immune system. Yet these students were only able to articulate medical models of health promotion. The team postulated that had the components of the course been identified, integrated and labelled as being health promotion, student attitudes, behaviour and values would have changed.

In the DipHE courses, a heavy concentration of the issues are presented in the Common Foundation Programmes but diminishes in the Branches. Thus the typical pattern was to begin with a unit or module concerned totally with 'normality' or normal functioning. Students learned generally about society. The second module was usually concerned solely with health education and health promotion. In two out of four centres there was no evidence that concepts about the nurses' role in either health promotion or nursing the sick was introduced at this stage. Students found it frustrating not to hear about disease or their future role at the outset of their programme.

Lecturers in all centres, reported that post-registration students were more likely to react positively to health promotion than the novices. As qualified practitioners they were motivated to know about health promotion and saw its value and clinical application, whilst the new recruits yearned for hands-on experience and high drama on the wards.

Clearly more post-registration education in health education is required and possibly new recruits could be allowed to participate in physical care skills earlier in their programmes. This might appease both the students and practitioners and demonstrate early on in their education the value of integrating health promotion into practice.

In Centre D where the DipHE teachers had a generalist rather than specialist role, health promotion had been better integrated into nursing curricula than elsewhere. The students were well disposed towards health promotion. Support for the topic had been given by the local health promotion officer. Furthermore,

the cohorts were small and the 20-30 students per intake (compared with over a hundred in other centres) were treated with concern and attention by their teachers.

A possible reason for lack of integration in two other centres concerned the design and interpretation of the curriculum. In one centre, teachers with masters degrees designed the curriculum but did little of the teaching. In another centre, the curriculum was designed by generalists and health promotion 'experts' had since joined the staff to teach it.

The most crucial findings from this study was that a philosophy of health and health promotion are represented in curricula but not in a coherent or integrated manner. With minimum changes to programmes an integrated philosophy could be achieved.

Separate Branch Cultures in Diploma in Higher Education (DipHE) Programmes

Furthermore we observed that in spite of health promotion being taught in the DipHE Common Foundation Programme the development of separate and distinct branch cultures further militated against integration.

One reason for the lack of continuity between CFP and the branches appeared to be because it was taught by general nurse teachers and its content was predominantly concerned with promoting physical health. Such an approach was seen as having less relevance for mental health and learning disability nurses than for adult and paediatric nurses.

Once students were in the branch programme, there was no evidence of shared learning in health promotion, no overlap of knowledge and reading lists were different, even though the concepts and principles are applicable to any client and situation.

Some branches, such as Learning Disabilities appeared more successful in integrating the newer paradigms of health promotion than others. For example, learning disability students in one centre referred to such concepts as empowerment, advocacy, assertiveness in describing their care of clients. In another centre, learning disabilities managers regarded the current DipHE students as having a broader view of care and more aware of clients' needs than traditional students.

We infer from these findings that shared learning between the branches could assist the integration of a philosophy of health throughout the DipHE programme and provide students with newer paradigms of health promotion more common in some specialties than others.

Practitioners as role models

The dominance of the medical model of health promotion and the lack of integration of a philosophy of health in the four case studies may be explained by the lack of role models and the nature of student placements.

The students saw that health promotion was important to their lecturers but when they looked to the clinical staff for support and guidance on their role they found it not always a priority for them.

The practitioners were concerned that the DipHE students were weak in basic physical care skills. It is likely to be difficult for the students to interact with patients in attempts to promote their health, when they feel inadequate about doing the most basic physical tasks.

Acute ward philosophies still interpreted health promotion within a medical model framework. We observed the predominant view held by staff was that if disease had occurred then it was too late for health education to take place except perhaps if there was time when the 'real' work of nursing was over.

We were exposed to negative attitudes to DipHE students from a number of nurses undertaking post-registration courses. For example, one group claimed that the students lacked communication skills. They were reported to 'just sit at the desk' and did not want to talk to patients. Generally, the clinicians reported the students were 'not in the mould' because their teachers told them they were 'special'. They preferred students who were former auxiliaries who presumably came with 'orthodox and traditional' views about nursing.

One nurse resented the fact that the DipHE students did not even know how to make a bed. She said *"I certainly don't have time the time to teach them, they should know before they come"*.

Even post-registration students who were committed to health promotion and had devised projects to apply it in their clinical areas found workload pressures prevented them from doing so.

As one post-registration teacher explained: *"To actually help with the awareness*

of health promotion in areas that are critically very busy you have to dig your heals in and say this is a priority, because the immediacy of the situation often decides what happens. There is a need to distinguish between immediate and other needs. As nurses we often focus on what a patient's needs are to the detriment of their emotional health ... We've got to care holistically: not focus on clinical rules".

Placements - Health Enhancing or Health Damaging ?

It became increasingly evident that both students and qualified staff were unable to conceptualise a role for nurses promoting the health of sick people. The general concerns appeared to be that health promotion and health education were to be undertaken in the community, by community nurses and that the hospital was not the appropriate environment for such activities. As one post-registration critical care student realistically put it: *"the emphasis is still on illness (in the clinical environment) and that's the way our jobs are structured unfortunately".*

DipHE students gave examples of opportunities for health promotion on their last clinical placements which clearly reflected the medical model. A student who had recently completed a placement in an Accident and Emergency Department, described how she had given advice on diet and exercise for a patient suffering a myocardial infarction and a leaflet on child safety for parents of a child brought in following an accident. Given the acuteness and severity of the two examples it appeared the prevention and lifestyle models of health promotion were used inappropriately . The student had apparently not been exposed to staff using relaxation techniques and counselling for people in pain, fear and discomfort. Generally the victim-blaming phenomenon persisted, even though it has been shown to be ineffective.

One student gave this response to a question about the opportunities for putting theory into practice in the acute areas.

"Fairly limited and restricted by staff. Let's face it, you've got to be seen to be doing 'real' nursing haven't you? (if you want to pass your placement) What is important is that we are aware of the importance of health education and health promotion - we often don't get the chance to engage in it!" (Centre C, Second year Student).

Another student commenting on the practitioners' commitment to health promotion said: *"there's not much enthusiasm really".*

Post-registration students in the north were willing and able to attempt to integrate health promotion into their practice, but were waiting for the right opportunity to do so.

As one student from this group put it: *"Health education is not only of patients but also friends, family and colleagues. There should be a teaching programme where everybody contributes and learns because not everybody knows everything. You need to cascade the information down throughout the (operating theatre) department. It's* ***a life philosophy*** *if you like"* (Researchers' emphasis).

Midwifery students and post registration students on the ENB HIV/AIDS course expressed views that if nurses wanted to promote health they would be health visitors - implicitly stating that promoting health can only be done with people who are already well.

However, our findings suggested that district nurses and health visitors still tended to work with clients on a one to one basis within a medical or educational perspective. As our key informant in Centre E cautioned, neighbourhood nursing introduced as a way of organising district nursing was *"a little bit in danger of almost translating institutional care into the community"*.

If new roles to actively enhance health are being advocated then new role models for practising nurses, midwives and health visitors are required. Using students as the agents of change is both stressful for students and threatening for trained staff.

A member of the research team recalled similar reactions in discussions on the introduction of the nursing process in the eighties. Similarly trained staff felt that the nursing process was something to do with students and teachers but nothing to do with them.

It was suggested that more shared learning on health promotion issues between DipHE students and qualified nurses in post registration courses would go some way to increasing co-operation, communication and understandings between students and trained staff.

Currently designated health promotion placements in both non- and institutional settings are with 'normal' representations of our society e.g. visiting families with community nurses, occupational visits to steel works and nuclear plants. In these placements, students are likely to observe situations which **undermine** rather than enhance health (Researcher's emphasis).

Our key informant at Centre E, suggested that community placements for students needed to be more creative than at present. She questioned the value of placing students for eight hours with clients with learning disabilities without adequate preparation. She proposed showing the students a trigger video and seminar followed by shorter contact time.

Both students and teachers suggested that more benefits could be derived from current placements with improved preparation and feedback.

Many students no longer live in residencies but at home with their families and may require more time in the timetable for feedback from placements. We observed academic sessions were sometimes used for emotional release rather than the intended purpose of the session. More opportunities may be necessary for them to discuss the 'horrors' of disease and disability. The culture of repressed emotions and professional distance still persist.

There were no links with local community development projects, although one teacher was investigating placement possibilities. These projects offered opportunities for students to experience social and political models of health.

With large student numbers however, creative placements pose a difficulty. Community nurses were already over burdened by the number of students accompanying them.

The research team concluded that students needed to observe health care workers actively using newer paradigm approaches to promote the health of both well and sick people.

What does Health Promotion mean for Nursing, Midwifery and Health Visiting ?

We identified a number of allied concepts and skills frequently associated with a philosophy of health. Many of them incorporated concepts and skills 'traditionally' associated with definitions of nursing, midwifery and primary care such as holism, communication and caring.

For example: DipHE Branch students proclaimed during discussion that 'health education and health promotion is the caring role' and a 'philosophy of health puts the emphasis on holism and the whole person'.

Thus *"a big part of a philosophy of health was to take time, interact and*

communicate with patients in a way that's beneficial to them".

For a post-registration student a philosophy of health was *"like taking the patient and family holistically".*

Dines and Cribb (1993) suggest concepts such as holism, partnership, public participation, collaboration, equity, co-operation and enabling are relevant to health promotion.

The following quotation from one post-registration teacher illustrates this view:

"Initially when I decided to be a nurse I thought you did everything for the patients. But I don't think that now. It's like driving the car in the back seat. You hope to enable those people to support them and look after them in caring for their families".

Gallagher and Burden (1993) however dispute that nursing and health promotion are synonymous. Central to professional nursing is the development of a therapeutic nurse-patient relationship of which health promotion and empowerment are just aspects.

Health Promoting Institutions

It is difficult to teach health promotion in an unhealthy college or hospital. Attempts have been made to improve the physical health of workers and students with the introduction of no smoking policies and healthy eating programmes, but those institutions still remain psychologically demanding. Students in Centre D have assertiveness courses and stress management programmes. Assessments in Centre A have been adapted to make them less stressful and the health promotion lecturer attempts to work in empowering ways when teaching.

But more needs to be done to help students feel empowered and confident enough to work as a health promoter in the hierarchy of the health service.

There was also evidence in curricula and classrooms of ethnocentric and sexist use of language and these concepts are in direct contradiction to the principles of health promotion.

Some poor teaching accommodation was observed. In two centres old psychiatric and fever hospitals were used. Poor accommodation will not promote a feeling of self-worth in students and staff.

In another centre the nurses' homes were being sold off to property speculators and students were being offered alternative accommodation many miles away.

Levels of stress were high in all centres, closures and redundancies and constant organisational change were common place. Staff and students' coping strategies were variable. Clinical practitioners were also experiencing high levels of stress and uncertainty.

Some of the changes to a philosophy of health were seen as too ambitious. In three centres staff had been encouraged to obtain higher degrees, yet generally the move to the Diploma in Higher Education (DipHE) had been seen as urgent and staff did not feel they had had enough time to reflect and prepare themselves.

It was also noted that courses are now more likely to be finance rather than student driven.

General Academic Issues

The research team concluded that generally academic levels observed were low for diploma level and tended towards general discussions rather than academic debate. Students seemed to need the time to recount anecdotes and to release emotional tension. Practically no note taking was observed and there was little reference to research or theory.

A representative from one centre challenged our interpretations of the teaching level, during feedback. The format of the classes was defended by stressing that the emphasis was on the relationship between tutor and student rather than the content of the sessions. If the students felt confident and motivated about studying, then they could explore the 'facts' themselves. It was also stated that students have core formal lectures supported by informal seminar groups.

Of specific relevance to the level and content of post-registration education, the following issue was raised. Qualified nurses were described as being bright, intelligent and motivated on courses, but lacking an academic approach to study. Implications for PREPP might be that in future two types of courses might be needed including one specific course to develop academic skills for those who have not had an academic background.

All colleges had achieved joint professional and academic validation.

The advantage of running programmes from an institution of higher education

rather than a college of nursing was noted at Centre E where a much wider range of influences and expertise were available to develop and teach health based curricula.

Opportunities for the Diploma in Higher Education (DipHE) to become a degree qualification after further study exist in Centres A and D.

The concept of shared learning is being developed and is only taking place in the Common Foundation Programme in Centre C between DipHE students and the direct entry midwifery students. Health visitor and district nursing students taking a post-registration diploma in community nursing at Centre E shared learning with BSc undergraduates.

CHAPTER 11

CONCLUSIONS AND RECOMMENDATIONS

This illuminative evaluation produced rich and interesting data. As the case studies show each centre created its own 'story' of the shift towards a philosophy of health. The following conclusions and recommendations are derived from our analysis, interpretations and discussion of our findings presented in chapters 5-10. In order to create a model to assist other researchers, educationalists and policy makers we have identified certain factors which enhance integrated curricula and other factors which hinder integration. These factors are represented diagrammatically at the end of this chapter.

The study's main conclusion indicates that on balance a philosophy of health has **not** been successfully integrated into nursing and midwifery curricula. In the Diploma in Higher Education (DipHE) courses, issues relating to a philosophy of health and health promotion are concentrated within the first few months and then tend to diminish in importance and emphasis. Although we found many aspects of the body of knowledge required for health promotion represented in the curricula, it appeared in fragmented and disjointed ways, which made it inaccessible for students. Health visitor and district nursing diplomas have integrated concepts of health and health promotion into their curricula more successfully. Other post-registration courses have however had difficulty integrating these concepts.

Our recommendations to remedy or prevent this situation include:

Concepts of health and health promotion should be revisited regularly throughout all courses. The Branch programmes need to continue the momentum and enthusiasm generated in the Common Foundation Programme.

Consolidation classes need to be designed and taught by a lecturer with a relevant higher degree. During the sessions, components of health promotion taught in other modules or topics need to be identified and integrated into the students' nursing or midwifery skills.

Secondly, the majority of students held medical and educational models of health promotion. Students commonly gave examples of preventive advice on lifestyles, leaflets and smoking cessation. All responses were confined to promoting physical health. There was little evidence of familiarity or use of the newer more progressive paradigms.

We recommend therefore that:

Students be exposed to both the theory and practice of the social and political models of health promotion and these approaches are reinforced and integrated into nurses' and midwives' repertoire of abilities and skills.

The newer paradigms become as much part of nursing and midwifery knowledge and theory as the medical and educational models.

Although these approaches are evident in some programmes, the practical applications need to be reinforced with examples of how these approaches can be applied clinically.

It was apparent in some centres there was a poor understanding of the body of knowledge and the skills required to implement health based curricula. There appeared to be an assumption that lack of disease or normal body functioning was the same as health and that health promotion came as a consequence of not discussing disease.

We recommend therefore that:

The body of knowledge which comprises health and health promotion be made more explicit by the policy makers and educationalists by acknowledging that time and education are required to perfect this innovation.

We concluded that the health care professions have not yet developed their own conceptualisation of health promotion for nurses and midwives. In some centres the concept of health in use was indistinguishable from a philosophy of health on health studies programmes.

Our recommendation on the basis of this finding is that:

Nurses and midwives need to develop their own *nursing* and midwifery strategy for promoting health which is distinctive from a generic philosophy of health. This could be achieved by creating a working party of experts convened by the ENB.

There was little evidence of shared learning between the Branches and students on other programmes. Shared learning occurred on the community nurses' diploma at the 'new' University (Centre E); these students were also taught by lecturers from a wide variety of disciplines.

Our recommendation is for:

Lecturers to be encouraged and supported in organising joint sessions of pre-and post- registration students.

We then concluded that the attitudes of the clinical staff towards the shift in philosophy of health are ambiguous and sometimes negative and unsupportive towards DipHE students.

Our recommendation therefore is for:

More emphasis on education and training for clinical practitioners and managers, to prevent DipHE students being used as agents of change.

With regard to Health Promoting Institutions we concluded that colleges and hospitals are making some progress towards creating a healthy environment in which to work and study, usually in modifying the physical working conditions. There is a rapid rate of change within the health service. Communication systems still tend to be vertical rather than hierarchical creating a climate of rumour, uncertainty and stress.

We recommend:

Improved communication between all levels of staff so as to reduce confusion and stress. Nurses, midwives and health visitors should be encouraged, educated and prepared to take their place on committees and working parties, so they can promote the professions' views and needs at a time of change.

Collaboration between occupational health departments and Health Promotion Units to collaborate on developing strategies for reducing the psychological strains imposed on students and health care workers. This could be achieved by the introduction of stress management courses, relaxation and assertion training.

Two models of lecturer preparation were observed. The first model was the specialist approach, where lecturers were supported in pursuing academic qualifications in their chosen subject. The second model was the generalist approach, where all staff taught most subjects. Each approach has its own strengths and weaknesses. In a specialist approach, lecturers achieve in-depth knowledge, along with a sense of self worth, commitment to their subject and academic credibility. Fragmentation of the curriculum however is possible when consolidation and communication is weak.

With the generalist approach, lecturers lack in-depth academic knowledge across all subjects often associated with lack of confidence (particularly if the lecturers are non-graduates). But there is the likely advantage of subject integration.

We recommend:-

The specialist model be adopted provided consolidation and integration are made priorities and lecturers are academically prepared in their chosen specialty.

Communication skills teaching and experiential learning were apparent in all DipHE curricula, but less so in some post-registration courses.

We recommend therefore that:

Communication skills teaching should be encouraged in all courses concerned with health promotion. Skills in negotiation, advocacy and lifeskills should be included.

Placements during the Common Foundation Programme were generally perceived to have limited success. Students usually experienced health damaging rather than health enhancing placements. Creative placements are difficult to achieve with large student cohorts. A creative and different format to placements needs to be developed with new role models. The only models of health promotion which students were exposed to used individualistic traditional approaches. The students looked to clinical practitioners as role models and for guidance on promoting health but found it was not always a priority for them.

We recommend:

Students are exposed to health care workers who are confident and able to promote the health of both well and sick individuals and communities. Lay health care workers, working in the voluntary sector, psychologists and social workers all work to promote mental health and could be approached to offer student placements.

The development of links with Community Action projects and Health Promotion Units in order to identify placements with health care workers who use social action models.

A lecturer/practitioner or facilitator could be developed with the principal aim of providing guidance and support for both students and qualified staff in enhancing and promoting the health of their patients and clients.

The Health Visiting profession has not been consulted in the design of DipHE curricula, nor has the experience of first wave demonstration sites been used to help and advise second and third wave colleges.

We recommend that:

The regulating bodies for Nurses, Midwives and Health Visitors encourage and recommend professional groups be consulted and their experience used for innovation.

It was apparent that the views of purchasers and patients and clients, about their health promotion needs had not been sought.

We recommend therefore that:

The perceptions, needs and health beliefs of patients and also of purchasers regarding the type and content of health promotion provided by nurses, midwives and health visitors needs to be elicited by further research. This could be undertaken in parallel with an action research project concerned with facilitating the integration of health promotion in nursing theory and practice.

Separate and distinct Branch Cultures exist which further inhibits the integration of a philosophy of health in the DipHE curriculum.

We recommend:

Shared learning and reading lists, placement exchanges and teaching by specialist lecturers across the Branches.

Lecturers, students and practitioners are unsure about the 'finished product' of a philosophy of health curriculum. The role of the DipHE diplomates and their ability to promote health needs to be established.

We recommend this might be achieved through:

Conferences and academic debate, workshops and consciousness raising activities to identify this topic as an issue for discussion in the profession.

Further research on the impact of a philosophy of health curriculum on practice and patient/client outcomes.

There is a myth of the 'useless' DipHE student. Practitioners in our study had difficulty in accepting the shift to a philosophy of health and negative attitudes were expressed about the diploma status of nursing students.

We recommend that:

More time, energy and resources are spent in developing practitioners.

Lecturers taking degree and diploma courses in 'nursing studies' reported that some courses had little health promotion content.

We recommend:

All colleges offering courses in nursing should be identified and surveyed by the ENB for their health promotion content and advised accordingly.

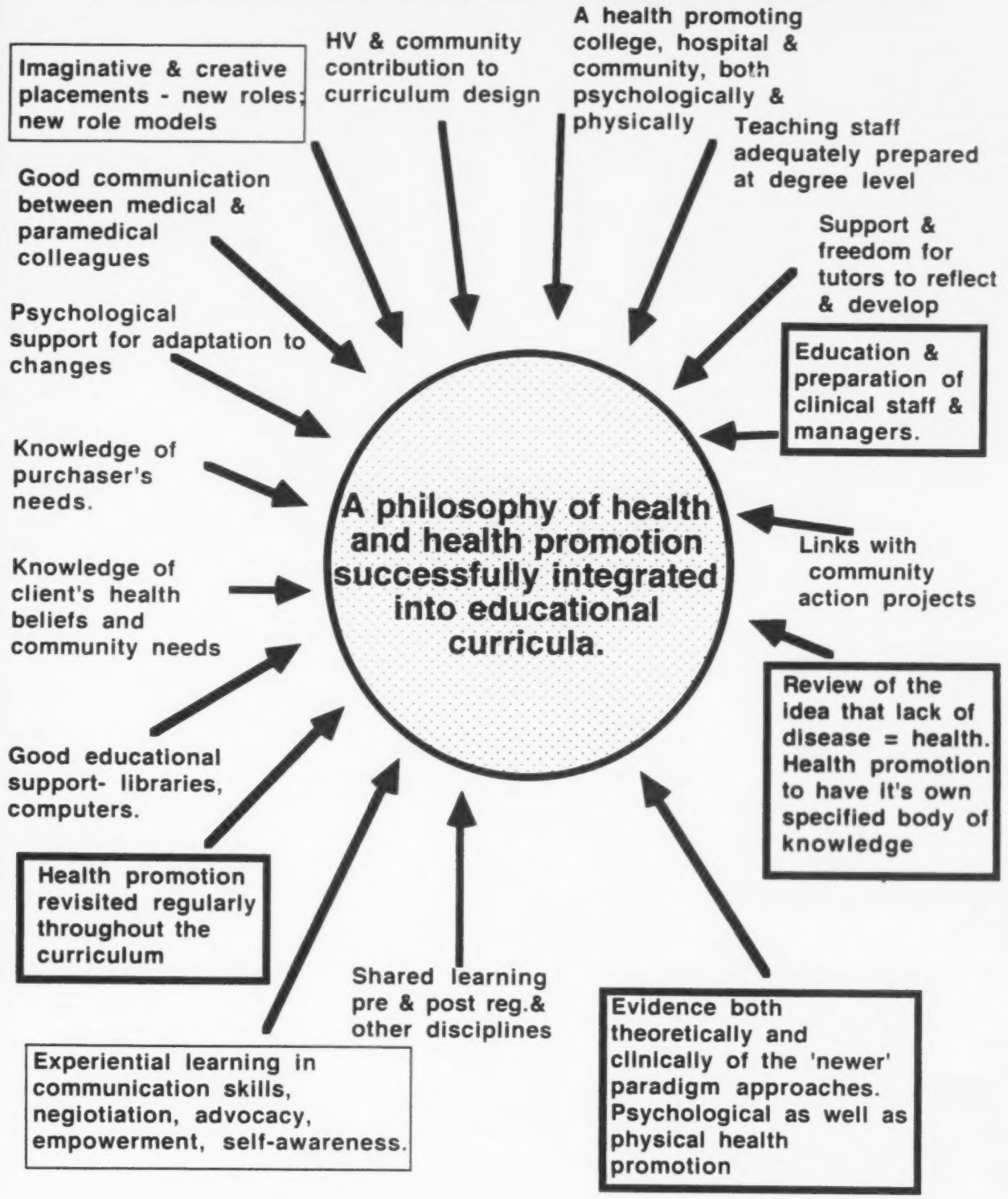
The NHS structural changes have resulted in competition between Health Promotion Units and Colleges of Health/Nursing and Midwifery.

We recommend that:

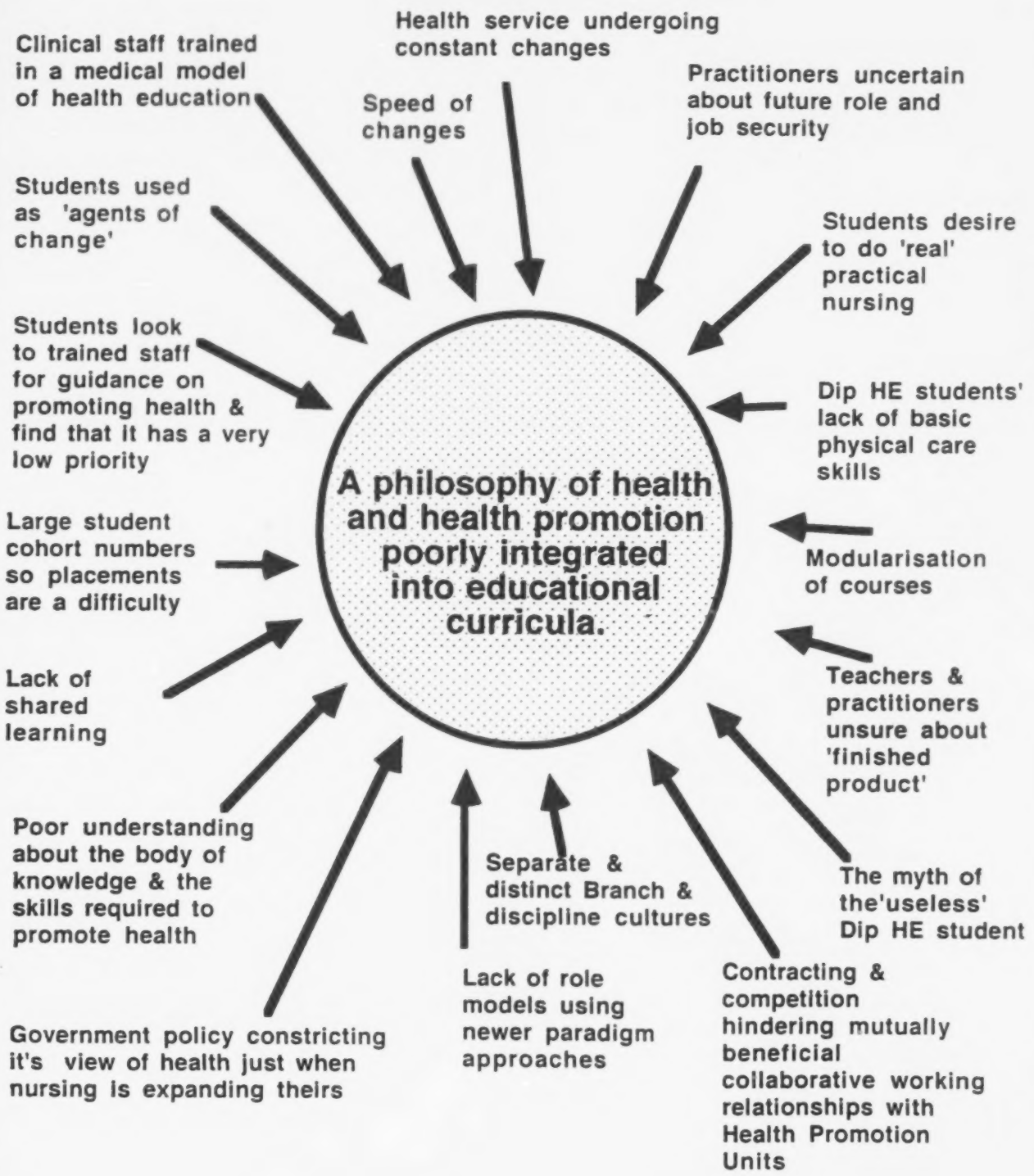
Nurse educationalists re-negotiate their community networks to keep abreast of changes in NHS and community care.

The diagrams below have been devised as an evaluation model by the research team in order to identify enhancing and hindering factors in integrating a philosophy of health as a basis for curricula. Those factors in emboldened boxes indicate a priority for policy action on the part of the ENB advisers. The thin lined boxes are about the processes of transmitting a health promoting theory. The other factors are associated with local initiatives such as organisation and collaboration between educationalists, managers and practitioners.

Enhancing factors affecting the integration of a philosophy of health and health promotion in educational curricula


A philosophy of health and health promotion successfully integrated into educational curricula.
Imaginative & creative placements - new roles; new role models
HV & community contribution to curriculum design
A health promoting college, hospital & community, both psychologically & physically
Teaching staff adequately prepared at degree level
Good communication between medical & paramedical colleagues
Support & freedom for tutors to reflect & develop
Psychological support for adaptation to changes
Education & preparation of clinical staff & managers.
Knowledge of purchaser's needs.
Links with community action projects
Knowledge of client's health beliefs and community needs
Review of the idea that lack of disease = health. Health promotion to have it's own specified body of knowledge
Good educational support- libraries, computers.
Health promotion revisited regularly throughout the curriculum
Shared learning pre & post reg.& other disciplines
Evidence both theoretically and clinically of the 'newer' paradigm approaches. Psychological as well as physical health promotion
Experiential learning in communication skills, negiotiation, advocacy, empowerment, self-awareness.

Hindering factors affecting the integration of a philosophy of health and health promotion in educational curricula


Clinical staff trained in a medical model of health education
Health service undergoing constant changes
Speed of changes
Practitioners uncertain about future role and job security
Students used as 'agents of change'
Students desire to do 'real' practical nursing
Students look to trained staff for guidance on promoting health & find that it has a very low priority
Dip HE students' lack of basic physical care skills
A philosophy of health and health promotion poorly integrated into educational curricula.
Large student cohort numbers so placements are a difficulty
Modularisation of courses
Lack of shared learning
Teachers & practitioners unsure about 'finished product'
Poor understanding about the body of knowledge & the skills required to promote health
Separate & distinct Branch & discipline cultures
The myth of the'useless' Dip HE student
Lack of role models using newer paradigm approaches
Contracting & competition hindering mutually beneficial collaborative working relationships with Health Promotion Units
Government policy constricting it's view of health just when nursing is expanding theirs

Appendix (i)

HEALTH PROMOTION
A WHO discussion document on the concept and principles

In January 1984 a new programme in 'Health Promotion' was established in the WHO Regional Office for Europe. It is the first programme of this kind in WHO and its development has had strong support from Member States. Planning began in 1981; since then a number of meetings, bringing together people from professional and academic disciplines and consumer groups, have helped to clarify the special approach of such a programme. This work has been documented by the Regional Office in a number of working papers and publications listed in the appendix.

As part of the continuing process of programme development, a working group met in July 1984 to discuss 'Concepts and Principles in Health Promotion'. This document is a result of that working group. It is designed to clarify some of the most important issues in relation to the development of policy and programmes in health promotion. It is not intended as a final statement, but as a focus for discussion on which to base the development of health promotion activities in Europe.

The group is fully aware that the development of priorities and practices for health promotion depends upon the prevailing economic and cultural conditions. In each country, region and district, health promotion should involve the full participation of all people in the development of their health.

At a general level, health promotion has come to represent a unifying concept for those who recognise the need for change in the ways and conditions of living, in order to promote health. Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future.

Basic resources for health are income, shelter and food. Improvement in health requires a secure foundation in these basics, but also: information and lifeskills; a supportive environment, providing opportunities for making healthy choices among goods, services and facilities; and conditions in the economic, physical, social and cultural environments (the 'total' environment) which enhance health.

The inextricable link between people and their environment constitutes the basis for a socio-ecological approach to health and this provided the conceptual framework for discussions by the working group. The discussions were organised around four main themes - principles, subject areas, priorities for the development of policies and dilemmas in health promotion.

Principles

Health promotion is the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment. Health is, therefore, seen a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities.

1. **Health promotion involves the population as a whole in the context of their everyday life, rather than focusing on people at risk for specific diseases.** It enables people to take control over and responsibility for, their health as an important component of everyday life - both as spontaneous and organised action for health. This requires full and continuing access to information about health and how it might be sought for by all the population, using, therefore, all dissemination methods available.

2. **Health promotion is directed towards action of the determinants or causes of health.** Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health. Government, at both local and national levels, has a unique responsibility to act appropriately and in a timely way to ensure that the 'total' environment, which is beyond the control of individuals and groups, is conducive to health.

3. **Health promotion combines diverse, but complementary, methods or approaches,** including communication, education, legislation, fiscal measures, organisational change, community development and spontaneous local activities against health hazards.

4. **Health promotion aims particularly at effective and concrete public participation.** This focus requires the further development of problem-defining and decision-making lifestyles both individually and collectively.

5. While health promotion is basically an activity in the health and social fields, and not a medical service, **health professionals - particularly in primary health care - have an important role in nurturing and enabling health promotion.** Health professionals should work towards developing their special contributions in education and health advocacy.

Subject area

Health promotion best enhances health through integrated action at different levels on factors influencing health, economic, environmental, social and personal. Given these basic principles an almost unlimited list of issues for health promotion could be generated: food policy, housing, smoking, coping skills, social networks. The working group sought to frame the **general subjects for health promotion** in the following areas:

1. The focus of health promotion is **access to health**; to reduce inequalities in health and to increase opportunities to improve health. This involves changing public and corporate policies to make them conducive to health and involves re-orienting health services to the maintenance and development of health in the population, regardless of current health status.

2. The improvements of health depends upon **the development of an environment conducive to health**, especially in conditions at work and in the home. Since this environment is dynamic, health promotion involves monitoring and assessment of the technological, cultural and economic state and trends.

3. Health promotion involves the **strengthening of social networks and social supports.** This is based on the recognition of the importance of social forces and social relationships as determinants of values and behaviour relevant to health and as significant resources for coping with stress and maintaining health.

4. The predominant way of life in society is central to health promotion, since

it fosters personal behaviour patterns that are either beneficial or detrimental to health. The promotion of lifestyles conducive to health involves consideration of personal coping strategies and dispositions as well as beliefs and values relevant to health, all shaped by lifelong experiences and living conditions.. **Promoting positive health behaviour and appropriate coping strategies** is key aim in health promotion.

5. Information and education provide the informed base for making choices. They are necessary and core components of health promotion, which aims at **increasing knowledge and disseminating information** related to health. This should include: the publics perceptions and experiences of health and how it might be sought; knowledge from epidemiology, social and other sciences on the patterns of health and disease and factors affecting them; and descriptions of the 'total' environment in which health and health choices are shaped. The mass media and new information technologies are particularly important.

Priorities for the development of policies in Health Promotion

Health promotion stands for the collective effort to attain health. Governments, through public policy, have a special responsibility to ensure basic conditions for a healthy life and for making the healthier choices the easier choices. At the same time, supporters of health promotion within governments need to be aware of the role of spontaneous action for health ie the role of social movements, self-help and self-care and the need for continuous cooperation with the public on all the health promotion issues.

1. **The concept and meaning of 'health promotion' should be clarified at every level of planning**, emphasising a social, economic and ecological, rather than a purely physical and mental perspective on health. Policy development in health promotion can then be related and integrated with policy in other sectors such as work, housing, social services and primary health care.

2. **Political commitment to health promotion** can be expressed through the establishment of focal points for health promotion at all levels - local, regional and national. These would be organisational mechanisms for intersectoral, co-ordinated planning in health promotion. They should

provide leadership and accountability so that, when action is agreed, progress will be secured. Adequate funding and skilled personnel are essential to allow the development of systematic long-term programmes in health promotion.

3. In the development of health promotion policies, there must be **continuous consultation, dialogue and exchange of ideas** between individuals and groups, both lay and professional. Policy mechanisms must be established to ensure opportunities for the expression and development of public interest in health.

4. **When selecting priority areas for policy development a review should be made of:**
indicators of health and their distributions in the population
current knowledge, skills and health practices of the population
current policies in government and other sectors.

Further an assessment should be made of:

the expected impact on health of different policies and programmes
the economic constraints and benefits
the social and cultural acceptability
the political feasibility of different options

5.**Research support is essential for policy development and evaluation** to provide an understanding of the influences of health and their development, as well as an assessment of the impact of different initiatives in health promotion. There is a need to develop methodologies for research and analysis, in particular, to devise more appropriate approaches to evaluation. The results of research should be disseminated widely and comparisons made within and between nations.

Dilemmas

Health related public policy will always be confronted with basic political and moral dilemmas, as it aims to balance public and personal responsibility for health. Those involved in health promotion need to be aware of possible conflicts of interest both at the social and the individual level.

1. **There is a possibility with health promotion that health will be viewed as the ultimate goal incorporating all life.** This ideology, sometimes called healthism, could lead to others prescribing what individuals should do for themselves and how they should behave, which is contrary to the principles of health promotion.

2. Health promotion **programmes may be inappropriately directed at individuals at the expense of tackling economic and social problems.** Experience has shown that individuals are often considered by policy makers to be exclusively responsible for their own health. It is often implied that people have the power to completely shape their own lives and those of their families so as to be free from the avoidable burden of disease. Thus, when they are ill, they are blamed for this and discriminated against.

3. **Resources, including information, may not be accessible to people in ways which are sensitive to their expectations, beliefs, preferences or skills.** This may increase social inequalities. Information alone is inadequate; raising awareness without increasing control or prospects for change may only succeed in generating anxieties and feelings of powerless.

4. **There is a danger that health promotion will be appropriated by one professional group and made a field of specialisation to the exclusion of other professionals and lay people.** To increase control over their own health the public require a greater sharing of resources by professionals and government.

Conclusions

The concept of health promotion is positive, dynamic and empowering which makes it rhetorically useful and politically attractive. By considering the recommended principles, subject areas, policy priorities and dilemmas, it is hoped that future activities in the health promotion field can be planned, implemented and evaluated more successfully. Further development work is clearly required and this will be an ongoing task of the **WHO Regional Office for Europe.**

APPENDIX (ii)

THE PROJECT 2000 DIPLOMA IN HIGHER EDUCATION DEMONSTRATION SITES

From Autumn 1989 thirteen Schools of Nursing began to pilot the Project 2000 Diploma in Higher Education. These were:

* Newcastle
* Sheffield
* East Suffolk and Great Yarmouth
* North East Essex
* North and South Bedfordshire
* Parkside
* Guildford
* Portsmouth and the Isle of Wight
* Winchester and Basingstoke
* Avon
* North Staffordshire
* Crewe and Macclesfield
* North Manchester

APPENDIX (iii)

Aims of this Study

* This research project aims to develop a model for evaluation which can be applied to the health promotion component of any nursing, midwifery or health visiting curriculum. An illuminative evaluative approach will be used.

* The purpose of the evaluation is to develop a framework to determine the extent and effectiveness of the health promotion component of these curricula, based on the concepts and principles recommended by the WHO in 1984.

* In-depth studies will be conducted on a range of pre and post registration courses in four centres. The studies will describe and evaluate how a philosophy of health has been implemented in relation to:

  . the course objectives
  . curriculum content
  . teaching methods
  . organisation of learning experiences/placements

* Factors for and against the successful implementation of a philosophy of health will be identified according to the institutions, specialties and educational levels studied.

Research questions

* How well does the syllabus of the programmes under study reflect the aims or principles of the curriculum ?

* Is the syllabus in harmony with the internationally agreed guide-lines on the concepts and principles of health promotion set out in 1984 by WHO ?

* What are the perceptions of course providers, course consumers, patients/clients and other nurses, midwives, health visitors,

regarding the process and outcomes of implementing a programme based on a philosophy of health ?

* By what criteria does the funding body (ie the English National Board [ENB]) measure success ?

Methodology

The design of this study will enable the development of an evaluation approach which can be applied to any educational curricula for nurses, midwives or health visitors, to determine the extent and effectiveness of the health promotion component of their course.

The conceptual model which influences the design of this research is that of illuminative Evaluation (Parlett & Hamilton 1977).

APPENDIX (iv)

QUESTIONS FOR PRELIMINARY VISITS

The aim of our meeting is to find out:

1. What courses do you offer ?

2. How many sites is your college located on ?

3. Which courses run on which sites ?

4. Could we please have copies of your curriculum document ?

5. Over the next few weeks (May/June) could you please give us details of:

   * details of the courses currently running in the College and on which sites ?

   * what types of placements relevant to health promotion will students be having and where ? (also at other times)

6. Could you please indicate other members of your teaching staff we should meet ?

7. How many staff have formal health education training/experience ? From where ?

8. What facilities are available: eg. Occupational Health; leisure activities; other.

9. Links with other agencies eg HEO, HPU ?

10. Who and what are the characteristics of the 'community' being served ?

11. What arrangements do we have to make for Ethics committee clearance ?

APPENDIX (v)

QUESTIONS FOR TUTOR INTERVIEWS

1. What are your views about this change in nursing/midwifery/ health visiting education towards a philosophy of health ?

2. To what extent were you involved in designing the new courses. What factors do you think influenced the content and structure of the curriculum. (WHO, Health of the Nation, UKCC) How were the changes managed - initially and subsequently eg evaluation. What sort of preparation were the teachers given eg education, time, workshops, information, recommended textbooks ?

3. In this curriculum how is the health/health education/health promotion taught, who does the teaching, (if necessary, is it taught in the social, behavioural and biological sciences -in nursing studies ?) how/why placements - what is the rationale behind these placements ?

4. How do you feel the new curriculum is working ?

5. Which areas do you think are working well ? less well ? (evaluation)

6. Have your views about promoting health changed at all since you began teaching/taking the course ?

7. If I were to ask you to describe the ideal student that your course might produce, what would she/he be like ? What skills would they have ? How would they differ from other students ?

8. What would you prefer the approach or views of your ideal student to be like ?

9. Do you feel that health promotion has an equal role to play in all the nursing specialties or are some areas more suited to i than others ?

10. Do you work in ways that promote health in the college generally (ie communication, hierarchy, approaches t problem solving, relaxation/stress, complementary therapy, sports, religion, unions -

Look for support for staff and students and strategies for approaching problems and stress

APPENDIX (vi)

CLINICAL STAFF INTERVIEW/DISCUSSION

KEY QUESTIONS

* **How do you feel about the changes in the curricula of nurses/ health visitors/midwives?** (moves towards changing the emphasis towards integrating concepts of health.)

* **What opportunities do you get in your clinical area for promoting your patients health?** (What do you understand health education/promotion to be) (prompt - participation in care, collaboration with other agencies or community staff, empowerment of patients and staff, nurse management structures, patient education/ information, lifestyle advice, stress management, complementary therapies, patient advocacy)

* **Are the students who have been on these courses different in any way ?**

* **What factors enhance or enable you and your students to be effective health promoters?**

* **What factors hinder you ?**

* **Have the changes made you think about your own health in any way? Has the ward changed at all to accommodate this?** (Look for changes in communication, stress- coping strategies, empowerment, life-style-smoking etc.)

* **Why do you think there has been this change of emphasis? Do you think it is for the better or worse?** (Focus on change from illness to health, not overall change to Project 2000 ie school of nursing to college education, look for influences like UKCC, WHO)

* **If I asked you to describe your ideal student what would she/he be like? What skills and abilities would they have?**

APPENDIX (vii)

'OTHER' INTERVIEWS

Interview/ key question/ discussion/ health promotion/ occupational health/ others

* What involvement have you had with the new nursing curricula/teaching nurses?
(Planning, education, stress etc.)

* What do you think about the changes - from illness emphasis to health ? How do you think it is working ?

* How do you think it could be improved ?

* What factors do you think are hindering its progress ?

* Generally, do you think the nurse can successfully incorporate a health promotion/education component into her role ?

APPENDIX (ix)

Form A

E.N.B. RESEARCH PROJECT 1993

One of your teaching sessions this week will be spent working with nursing researchers who are interested in health and health promotion.

We would like to spend the session with you exploring your attitude towards health promotion, in the following ways:

* researchers introduce you to the research project;

* students work in groups of 3 - 4 discussing the questions on this questionnaire;

* each group identifies somebody to report back your ideas to the whole class. (Ohp plastic and pens will be provided);

* each group reports back on one or two questions only. (We will sort this out at the beginning);

* whole class discussion;

* each student completes their own questionnaire to hand in to us.

We plan to tape record the session - all your comments will be confidential and anonymous.

Thank you very much for your help and co-operation.

APPENDIX (viii)

CLASSROOM OBSERVATION
Place:
Date:
Time:
Student Group:
Topic:

CONSIDER:

* **student response**
* **activities**
* **methods**
* **style**
* **content**
* **resources/aids/ohps**
* **lecturer**
* **number of students/absences**

Researcher:

1. What is your understanding of health promotion/health education?

2. Have your views about health promotion/health education changed at all since you began your education here ? If so, in what way ?

3. *In what ways have you been able/think you will be able to apply your theory about health promotion into practice in the clinical area ?*

What helps you ?

What hinders you ?

4. *What sort of activities might you expect a nurse, health visitor/midwife who is promoting health to be engaged in ?*

5. *What opportunities have you had in your last placement for promoting health ?*

9. *Staff Nurse Wanda Phule has recently received the World Health Organisation Gold Medal Award for Services to health promotion. What skills might she be expected to have ? !!*

10. *Do you have any other comments you would like to add to your answers regarding this project ?*

Thank you again for your help.

Sandra Lask
Project Leader

6. *How might a student enhance her/his own health ?*

7. *In the last 6 months what strategies have you employed to promote your own health ?*

8. *How has your teaching in sociology, nursing politics, psychology and biology contributed to your understanding of health ? Please comment on each of these disciplines.....*

APPENDIX (x)

Form B

E.N.B.RESEARCH PROJECT 1993

One of your teaching sessions this week will be spent working with nursing researchers who are interested in health and health promotion.

We would like to spend the session with you doing the following:

* students read the extract (below) adapted from an article called: Devaluation of Biological Knowledge by Barbara Drew in IMAGE: Journal of Nursing Scholarship. Vol.20 No.1 Spring 1988;

* think about the article and the questions below;

* discuss in small groups of 3 - 4 your reactions and interpretations;

* large group discussion (taped) about your reactions to the extract.

read on.....

I have a recurrent nightmare about nursing that goes like this:

I awaken from a coma and, with mounting panic, gradually perceive the sights, sounds, and smells of the intensive care unit. I hear the sighs and incessant, noxious buzz of a ventilator alarm as well as the intermittent click of a nasogastric suction apparatus. From chandeliers on either side of my bed hang intravenous solutions decked with labels and red stickers reading "double strength". A half dozen infusion pumps, with lights blinking, occasionally refill their piston-type syringes. When I try to move my restrained arms, I hear a "bong-bong-bong" and look over my right shoulder to see not only an electrocardiographic tracing but also the two waveforms of arterial and pulmonary artery pressures. That explains the pain in my groin where these invasive lines no doubt are inserted.

Fighting to control my terror, I suddenly realise that the one person who can help me is my nurse. My nurse will move with confident familiarity through the morass of technology in my room. I will trust my nurse's assessment of priorities and quick, efficient movements because they are based on comprehension of sound scientific principles. My nurse will be an expert in arrhythmia interpretation, evaluation of haemodynamic data, analysis of

acid-base abnormalities, titration of potent vasoactive drugs, prevention of infection and other iatrogenic complications.

Suddenly I am seized by a coughing spasm, which sets off all sort of ventilator alarms. I am choking and I believe that I am dying. I am outraged as a physiotherapist suctions me without prior hyperinflation and preoxygenation. She obviously doesn't know about the important nursing research on proper suctioning technique. How can I trust her to prevent endotracheal trauma from excessive negative suction pressures ?

A cardiology technician enters to change stopcocks and haemodynamic monitoring tubing without first washing her hands. A physician's assistant changes my groin dressing without wearing sterile gloves.

Finally my nurse enters, sociology, psychology and health promotion texts tucked under one arm. She has been interviewing my family and has assessed my psychological and cultural needs. When I am stable she will educate me about some deleterious life-style habits I engage in.

I am horror-stricken to discover that my nurse will not be orchestrating my physical care but rather delegating to less-trained technicians the life and death judgements that I count on her to make, minute by minute, twenty four hours a day, seven days a week: until I am out of danger.

Waking from my nightmare, I ponder several questions. When is it that society turns to nurses for help ? Do nurses study about diseases and sick people any more ? Why is it that nursing research seems to ignore the work of nursing, which draws heavily from the biological and physical sciences ? Do the social and behavioural sciences offer sufficient knowledge and training for the care of the critically ill ?

The position advanced here is that, in recoiling from the male-dominated, reductionist, disease orientated biomedical model, nursing science has (perhaps unintentionally) narrowed its scope primarily to study the social and behavioural sciences. In building a nursing science that devalues knowledge from the biological sciences we have "thrown the baby out with the bath water".

Well, what do you think ? Have we **thrown the baby out with the bath water** ?

Do you think the pendulum has swung too far in favour of health promotion and the social sciences ?

Where do you think the emphasis should be for nurses ? 50/50 ?

Which do you think you are best prepared to do - promote health or care for sick people ?

Thank you for your co-operation

Sandra Lask
Project Leader

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